Bundle Quality, Safety & Experience Committee 3 July 2020

Unfortunately we are presently unable to accommodate attendance by members of the public to our Health Board's committee meetings due to Covid-19 restrictions. However we will publish our draft minutes within 3 working days of the meeting taking place on our website.

1.1 09:30 - QS20/105 Chair's opening remarks

1.2 09:32 - QS20/106 Declarations of interest

1.3 09:34 - QS20/107 Apologies for absence

1.4 09:35 - QS20/108 Minutes of previous meeting held in public 5.5.2020 for accuracy, matters arising and review of summary action log

QS20.108a Minutes QSE 05.05.2020 Public draft v0.05 final draft.docx

QS20.108b Summary Action Log.docx

2 09:45 - QS20/109 Infection Prevention Report

Gill Harris
Amanda Miskell in attendance
The Committee is asked to note the report

QS20.109 IPC QSE report v 4.docx

3 10:00 - QS20/110 Serious Incident Report – April and May 2020

Gill Harris
Matthew Joyes in attendance
Recommendations:
The Quality, Safety and Experience Committee is asked to
note the report.
note the changes of Welsh Government serious incidents reporting requirements
note the implementation of the Make it Safe process.

QS20.110 Serious Incident Report – April and May 2020.docx

4 10:15 - QS20/111 Putting Things Right (PTR) annual report 2019/20

Gill Harris
Matthew Joyes in attendance
Recommendation:
The Committee is asked to approve the PTR 2019/20 annual report which is currently being translated.

QS20.111a PTR Annual Report 2019.20.docx

QS20.111b PTR Annual Report Appendix A - 2011 No. 704 Regulations 2011.pdf

QS20.111c PTR 2019.20 annual report - Appendix B - PTR Annual Report V0.8.docx

5 10:25 - QS20/112 Draft Annual Quality Statement 2019/20

Gill Harris
Matthew Joyes in attendance
Recommendation:
The Committee is asked to
note Appendix A Annual Quality Statement Editorial Group, Terms of Reference (ToR)
note Appendix B Welsh Health Circular titled "Annual Quality Statement 2019 / 2020 Guidance" Welsh Government
discuss Appendix C. Annual Quality Statement 2019/20 first final draft

QS20.112a Draft AQS 2019.20.docx

QS20.112b Draft AQS Appendix A- ToR.doc

QS20.112c Draft AQS Appendix B- Welsh Health Circular.pdf

QS20.112d Draft AQS Appendix C- AQS 2019-20 V0.5.docx

6 10:30 - QS20/113 Safeguarding annual report 2019/20

Gill Harris
Michelle Denwood in attendance
Recommendation:
The Committee is asked
to note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the recognised improvements and outcome of the Peer review of the Assurance Framework of the National Safeguarding Maturity Matrix (SMM)
Recognise the significant improvement to achieve Substantial Assurance as an outcome of the Internal Audit of BCUHB Safeguarding Governance review.
approve the Corporate Safeguarding Priority Action Plan for 2020-2021.

QS20.113a Corporate Safeguarding Annual Report V0.09.docx

QS20.113b Final Draft Appendix 1 Annual Report_Adults QSE 3rd July 2020. 2019-2020. V 0.012.docx

QS20.113c Final Draft Appendix 2 Annual Report_Children QSE 3rd July 2020. 2019-2020. V0.11.docx

7 10:45 - QS20/114 Essential services report

Gill Harris
Jill Newman in attendance
Recommendations:
The committee is asked to:
note the content of this report
recognise that the health board has taken steps to understand its ability to comply with essential services and in doing so has identified areas of particular challenge that need to be addressed as priority areas in the Q2 operational plan.
note the need to continue to monitor, escalating as appropriate, compliance with revised Essential Services guidelines in order to mitigate the risk of harm

QS20.114a Essential Services v2.5.docx

QS20.114b App2 Essential Services.2.2.pdf

8 11:00 - QS20/115 Waiting list management report

Gill Harris
Recommendation:
The Committee is asked to note the content of the paper.

QS20.115 Waiting list management QSE June 2020 V1.3.docx

9 11:15 - QS20/116 Pharmacy and medicines management report

David Fearnley
Recommendation:
The Committee is asked to receive the report for assurance

QS20.116 Pharmacy_Medicines Management report June 20.docx

10 11:25 - QS20/117 Mortality review update

David Fearnley
Recommendation:
The Committee is asked to note the content of this paper and support the proposed way forward - recognising that progress has been halted due to the Covid 19 pandemic.

QS20.117 Mortality review update.docx

11 11:35 - QS20/118 North Wales Vascular Review update

David Fearnley
Recommendations:
The Committee is asked to
note the progress made by the Vascular Task and Finish Group
approve the draft terms of reference for the Group

QS20.118a Vascular Update July 2020 v1.0.docx

QS20.118b App1 Draft ToR Vascular Network Task and Finish Group.docx

QS20.118c App2 Draft Vascular Service Improvement Plan v0.3.docx

QS20.118d App3 Vascular Stakeholder Engagement Plan.docx

12 11:45 - QS20/119 Annual assurance report on compliance with Nurse Staffing Levels (Wales) Act

Gill Harris
Recommendation:
The Committee is asked to note the report

QS20.119a Annual Nurse Staffing assurance report June 2020.docx

QS20.119b Annual Assurance Report on compliance with the Nurse Staffing Levels - July 2020.docx

QS20.119c Appendix Nurse Staffing Levels - July 2020.docx

13 11:55 - QS20/120 Nursing Workforce

Gill Harris
Recommendation
Acknowledge the report and assurance regards the escalation triggers and receive further reports should the need arise to vary Nurse Staffing levels from those previously reported

QS20.120a Nursing workforce.docx

QS20.120b App1 CNO letter.pdf

QS20.120c App2 Section 25B ward profiles and Nurse Staffing levels.docx

QS20.120d App3 Clinical Model.docx

14 12:05 - QS20/121 Quarter One Plan monitoring report (Q1PMR)

Jill Newman in attendance
Recommendation:
The Committee is asked to note the report

QS20.121a OPMR Quarter 1 2020-21 end of May 2020.docx

QS20.121b Quarter One Plan Monitoring Report_end May 20 v2.0.pptx

15 12:15 - QS20/122 Quality and Performance Report

Jill Newman in attendance
Recommendation:
The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

QS20.122a QAP.docx

QS20.122b QAP May 2020 FINAL v2.pdf

16 12:30 - QS20/123 Corporate risk register

Gill Harris
Recommendations:
The Quality, Safety and Experience Committee (QSE) is asked to:
1\. Consider the relevance of the current controls in place\.
2\. Review the actions in place and consider whether the risk scores remain appropriate for the present risks in line with the Health Board's risk appetite\.
3\. Approve the actions that have been completed and turned green so that they could be archived and replaced with new ones as deemed appropriate\.
4\. Approve an extension to the target risk dates for the following Health & Safety risks \(CRR20\, CRR21\, CRR23\, CRR24\, CRR25 and CRR26\) as per each request articulated within the report
5\. Approve and recommend the Corporate Risk Register \(CRR\) to the Audit Committee for approval and to gain assurance that risks articulated on it are managed in line with the Health Board\`s risk management strategy and best practice\.

QS20.123 Corporate Risk Assurance Framework Report v2.docx

17 12:40 - QS20/124 Summary of business considered in private session

Gill Harris
The Committee is asked to note the report

QS20.124 Private session items reported in public v1.0.docx

18 12:45 - QS20/125 Documents circulated to members between meetings

05.05.2020 - Integrated Quality & Performance Report (IQPR)
07.05.2020 - Guidance Note - discharging Board / Committee Responsibilities during COVID-19 response phase
06.10.2020 - Health & Social Care (Quality and Engagement) (Wales) Act 2020

19 12:47 - QS20/126 Issues of significance to inform the Chair's assurance report

21 12:50 - QS20/127 Date of next meeting 28.8.20

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality, Safety and Experience (QSE) Committee

Minutes of the Meeting Held in public on 05.05.20 via Webex

Present:

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

In Attendance:

Mrs Gill Harris	Deputy Chief Executive / Executive Director of Nursing and Midwifery
Mrs Jill Newman	Director of Performance
Mr Matthew Joyes	Interim Associate Director of Quality Assurance
Mrs Fiona Giraud	Director of Midwifery and Women's Services
Mr David Fearnley	Executive Medical Director
Mrs Lesley Singleton	Interim Director of Mental Health & Learning Disabilities
Miss Claire Brennan	Head of Office, Executive Director of Nursing and Midwifery

AGENDA ITEM DISCUSSED	ACTION BY
QS20/79 Chair's Opening Remarks **QS20/79.1** The Chair welcomed everyone to the meeting and confirmed that, as in the March meeting, the decision had been taken to reduce attendance and prioritise discussions within the agenda, to allow Executive officers and other senior leaders to fully focus on the response to the COVID 19 pandemic.	
QS20/80 Declarations of Interest **QS20/80.1** None were declared.	
QS20/81 Apologies for Absence **QS20/81.1** None were declared. **QS20/81.2** Revised attendance arrangements were reiterated with regards to Executive Officers and senior leaders being stood down due to response arrangements to COVID-19 pandemic.	
QS20/82 Minutes of Previous Meeting Held in Public on the 17.03.20 for Accuracy, Matters Arising and review of Summary Action Log **QS20/82.1** Cllr Cheryl Carlisle clarified that whilst her apologies were noted for the previous meeting, she had made several attempts to join the meeting but was unable to do so due to technical issues which had prevented her attendance at the meeting. A sentence will be added to the minutes to reflect this.	

QS20/82.2 The Committee Chair referred to item QS20/41 Action log from Joint Audit and QSE Committee and the particular action for a letter to be drafted to the clinical audit department. The Committee Chair informed the Committee that the letter had been drafted but had not been disseminated due to the suspension of clinical audit activity in respect of COVID-19 pandemic but this will be sent once clinical audit services are resumed.	
QS20/82.3 Amendments to typographical errors are required to be made within paragraph QS20/56.1.	
QS20/82.4 Updates were provided to the summary action log, noting a number of actions have been deferred until normal business resumed following COVID-19	
QS20/82.5 The Executive Director of Nursing highlighted the need to review the length of time papers are to be deferred and discuss in line with any plans to return to normal business reporting arrangements. It was agreed that the Committee Chair and Executive Director of Nursing will discuss further outside of the meeting.	**GH / LR**
QS20/82.6 The Executive Director of Nursing also referred to the interim governance arrangements paper for Board and Committees. It was agreed to share this with members.	**GH**
QS20/82.7 The Executive Director of Nursing proposed that a safeguarding report, which the Associate Director of Safeguarding is drafting, be presented to the next QSE Committee, which was agreed by members. It was noted that reports are now being received by QSG.	**GH**
Qs20/82.8 The Director of Performance advised that, although the IQPR had been stood down as agenda item, IQPR reports are still being prepared for Board, QSE and Finance & Performance Committee for members' information, albeit without exception reporting narrative. The version prepared for QSE members will be circulated to members outside the meeting.	**CB**
QS20/84 COVID-19 Update	
QS20/84.1 The Executive Director of Nursing and Midwifery provided an overview, confirming that temporary 'field' hospitals have been set up but are not yet being utilised outside of acute and community hospitals for COVID related purposes. Social distancing has been successful in reducing the peak to a level below that originally anticipated, however, further peaks are expected particularly if social distancing is reduced and work is ongoing in line with revised modelling to ensure capacity for anticipated level of attendances over the coming weeks and months.	
QS20/84.2 The Executive Director of Nursing and Midwifery highlighted key points to members. In relation to care homes and working with Local Authorities it was noted that a care home cell has been established focusing on support to care homes to address a number of challenges particularly around elderly patients requiring domiciliary care and the need to work closely with LA and care home colleagues to understand the impact on activity and beds particularly as we venture into autumn and winter months.	

Work is also ongoing to mitigate risks for both Health Board and care home staff and support is being provided to care homes in respect of infection prevention, in particular with some of the PPE (fit test masks), medicines and other areas with high levels of sickness in care homes. **QS20/84.3** The Executive Director of Nursing and Midwifery referred to safeguarding activity and a drop in activity in some areas with the exception of domestic violence. This to be considered in the future report to QSE **QS20/84.4** The Executive Director of Nursing and Midwifery advised that the clinical pathways group is considering the latest COVID modelling alongside emergency activity model and urgent elective to understand totality of activity required and the best way of delivery over the next few months. It was emphasised the need to safely bring back essential services, whilst also providing assurance and confidence to the public when attending hospital and minimising risk of harm associated with COVID. **QS20/84.5** The Executive Director of Nursing and Midwifery confirmed that PPE requirements have been modelled to ensure appropriate supplies are sourced. It was also noted that Standard Operating Procedures were drafted to provide assurance and confidence that where equipment has been donated has received relevant quality assurance checks prior to distribution across the organisation. **QS20/84.6** An Independent Member highlighted concerns around safety risks for patients from care homes attending acute sites / ED and the need for discussions to ensure safety when people are attending particular hospital / wards. It was noted that a care home cell had been set up. **QS20/84.7** An Independent Member expressed concern about Cancer services during COVID-19. The Executive Director of Nursing and Midwifery advised that surgery for urgent cancer will go ahead where this is possible to do so. There are restrictions within access to some of the tertiary providers i.e. in England who are not running at full capacity and these issues are being worked through. It was also noted that 'holding' treatments are alternative options for a finite period of time where feasible and work is ongoing with the cancer teams to review when there is a need to operate for those patients who have experienced delays. **QS20/84.8** There were discussions around the reduction in urgent suspected cancer referrals and reduced access to screening and diagnostic services, in particular endoscopy services which were partly due to BSG guidance to safeguard patients and staff from associated risks from aerosol generating procedures. The Executive Director of Nursing and Midwifery advised that weekly access meetings are reviewing every patient booked within essential services and to ensure that surgery can proceed for patients with cancer who reach the point for surgery, alongside work to ensure that a COVID free environment that is clinically most appropriate for patient. Cancer MDTs are working with patients to provide support for patients. It was highlighted that this would need further discussion within the group to ensure assurance of the processes to mitigate harm. **QS20/84.9** An Independent Member queried what communication processes are in place to convey relevant information to patients and it was confirmed that this is done through the MDTs. Communication processes will also be discussed through the	

Cancer Board meeting. The Health Board are also linking in with the Community Health Council for support in communicating key messages to the public. **QS20/84.10** The Chair referred to historical issues in backlog and diagnostics prior to COVID and queried how this will be addressed going forward following further delays as a result of COVID-19 and sought assurance that the Health Board has maximised every opportunity to try and utilise capacity. The Executive Director of Nursing and Midwifery advised that the review work being done currently is multifaceted covering access to GPs for referrals as well as options where work can be undertaken, including considering the use of other providers to review what options are available to begin to bring work back on locally. **It was resolved that** the Committee receive the verbal update.	
QS20/85 Infection Prevention Report **QS20/85.1** The Chair stated that this paper should be received for assurance not information and the coversheet to be amended. The Chair invited questions from Independent members. **QS20/85.2** An Independent Member raised two queries, firstly in relation to the previously raised concern about unavoidable infections and secondly whether there had been any learning from the outbreaks at Ruthin & Holywell community hospitals. **QS20/85.3** It was noted that the previous query in relation to unavoidable infections was included in the action log with response which confirmed that this can relate to an infected patient attending from another organisation or where MRSA, which is difficult to colonise, causes infection. Query was raised as to what actions are being taken to reduce infections, the Executive Director of Nursing and Midwifery agreed to provide further response on these actions and also clarify details regarding catheter infections following challenge to these infections being classed as unavoidable. **QS20/85.4** An Independent Member raised a queried in relation to removal of catheters and specifically whether urology data could be triangulated with figures. The Executive Director of Nursing and Midwifery agreed to clarify including details of the work programme going forward. **QS20/85.5** An Independent Member sought clarification on whether the infections that were attributable to other trusts / organisations were discussed with the organisation whether within or outside Wales. The Executive Director of Nursing and Midwifery confirmed that contact would be made with the organisation concerned and would clarify these results. **QS20/85.6** The Executive Director of Nursing and Midwifery advised the issues arising at Ruthin and Holywell Community hospitals were very similar. A learning review had taken place on 1st May and the outcomes of this are awaited which will be reviewed at the next QSG meeting. Concerns were raised about the length of time taken to review and the need to ensure the safety and risk of staff and vulnerable patients, it was acknowledged that whilst it was challenging during a pandemic outbreak, the lessons from the issues also needed to be learned as a matter of urgency to ensure they are	**GH** **GH** **GH**

communicated across all other areas including primary care and care homes. Early learning will be shared via infection prevention and area teams.	**MJ**
QS20/85.7 An Independent Member also queried whether Health & Safety have been involved and whether issues had been reported to the Health & Safety Executive (HSE). The Interim Director of Quality Assurance confirmed that national advice had been sought and a call taken place with HSE to ensure procedures are aligned with national expectations, and work is now ongoing with the Associate Director of Health, Safety & Equality to develop procedures in response to national advice received. It was also noted that incident reporting automatically generates RIDDOR reports and reporting to the WG serious incident framework. It was agreed that the Interim Director of Quality Assurance will ensure that QSE will received anonymised RIDDOR reports.	**MJ**
QS20/85.8 A discussion took place in relation to the previously raised query of difficulties in cleaning Ward 19 at YGC. The Executive Director of Nursing and Midwifery agreed to discuss this issue further at QSG and provide further response in respect of what cohort of patients were on the ward and whether it was fit for purpose in respect of cleaning difficulties.	**GH**
It was resolved that the Committee receive the report and feedback provided on the report would be actioned.	
QS20/86 Serious Untoward Incident Report	
QS20/86.1 An Independent Member referred to the incident relating to the death of a 13 year old and queried whether they were already known to the service. The Interim Associate Director of Quality Assurance advised that this incident related to PRUDIC processes not having been followed.	
QS20/86.2 An Independent Member referred to the incident relating to an early medical abortion and queried whether there was any significance to the two different types of medication referred to. The Interim Associate Director of Quality Assurance advised that this incident was initially reported to WG as a sensitive issue but WG had upgraded it to a serious untoward incident which had subsequently triggered further review and that further details would be provided following further investigation. Following concern about possible patient identifiable details, it was agreed to amend the report to remove reference to the GP surgery and republish this report.	**MJ**
QS20/86.3 The Director of Performance informed the group that BPAS had notified of a change in service due to COVID-19 and whilst there was no knowledge of whether the death related to the early medical abortion, an understanding was required of the changes to the service. It was agreed to clarify further details around the incident and what changes were made to BPAS service.	**JN**
QS20/86.4 The Chair emphasised the importance of understanding learning from serious incidents that are subject to rapid review and that these do not just drop off the reporting cycle.	
QS20/86.5 There were discussions regarding summaries of investigation reports, many of which identify process measures and issues picked up that were not what generated	

the original incident review. The Interim Associate Director of Quality Assurance advised that a revised more mature approach is to be implemented with a focus on human factors rather than a root cause. **QS20/86.6** The Executive Director of Nursing and Midwifery referred to the serious incident review process and the need to ensure appropriate scrutiny and oversight of incidents which should be reviewed at a senior leadership level centrally not locally. The Interim Associate Director of Quality Assurance confirmed that a quality improvement piece of work was being undertaken for the review process for every never event to be signed off by an executive and set out criteria for where incidents will be signed off. The Chair requested that the next meeting receive a report setting out the plan and terms of reference for incident reporting including process of analysis and actions to be taken. **QS20/86.7** The Executive Director of Nursing and Midwifery advised that the terms of reference for QSG will be reviewed to improve effectiveness and provide assurance. **QS20/86.8** There was a discussion regarding the never event in paragraph 4.4 on page 8 of the report relating to an investigation due for completion mid-March, the Executive Director of Nursing and Midwifery advised that this has been sent to a specialist to provide opinion on the review and advice on whether a full independent review is undertaken or not. Further update will be provided. The Committee expressed their concern that this review was not done independently originally. **It was resolved that** the Committee receive the report and feedback provided on the report would be actioned.	**MJ** **MJ** **MJ**
QS20/87 North Wales Vascular Service *Dr David Fearnley in attendance for this item* **QS20/87.1** The Executive Medical Director provided an overview confirming that at a meeting held between executive officers of both the Health Board and the NW Community Health Council (CHC) on 14th February 2019 a hard copy of the report was received and welcomed. It was agreed at this meeting that the Health Board report would be finalised to allow a comprehensive response to the concerns raised within the CHC report. Further agreement was confirmed between the Health Board and CHC to co-ordinate publication of both reports simultaneously. A meeting was held on 24th February with the Health Board Chief Executive Officer and members of the vascular team to review and cross reference both reports prior to joint publication of both reports. The Committee were informed however that a copy of the report had been leaked into the media. It was not known what version of the report was leaked. The Executive Director of Nursing and Midwifery advised that a joint statement would be circulated from the Health Board and CHC. **QS20/87.2** The Executive Medical Director confirmed that the Health Board report will be presented to the May Health Board meeting for further internal review to ensure that the report is explicit in addressing all concerns raised in the CHC report. The Health Board and CHC continue to work collaboratively to take account of surveys and focus groups as well as capture staffing, training etc and review the quality of the vascular	

service. It was also reported that the Health Board report has received endorsement from the Vascular Society which is an important piece of assurance and the Executive Medical Director emphasised the plans are to further improve the service, building on a previously approved model in order to provide the best evidenced based service. **QS20/87.3** The Executive Medical Director emphasised the collaborative working with the CHC which continues and clarified that progress has been made. Temporary changes have been made to the service which were linked to resignations and this was picked up by the CHC. **QS20/87.4** The Executive Director of Nursing and Midwifery advised that subsequent discussions held with the Chief Officer of the NWCHC in relation to the leaked report had resulted in the subsequent decision to send the report in confidence to people who had contributed prior to it being formally publishing later in May after the Board meeting. **QS20/87.5** The Chair enquired how much content had changed within the report in response to the CHC concerns. The Executive Director of Nursing and Midwifery advised that the report now included patient experience from surveys that had not previously been included. **QS20/87.6** An Independent Member referred to social media posts making reference to the need for Judicial Review and queried whether anything formal had been received in this regard. It was confirmed that the Health Board had not received anything in this regard. The Executive Director of Nursing and Midwifery advised that a number of questions in respect of vascular services had been sent to executives. Some issues had been addressed in response to the CHC report and emphasised the importance for a joint statement and implementation plan with critical oversight. **QS20/87.7** The Chair agreed to set out a series of questions and circulate to Independent Members for feedback and these would be sent to the Executive Medical Director for a response. **It was resolved that** the Committee receive the verbal update and feedback provided would be actioned.	**LR**
QS20/88 Stroke Care update **QS20/88.1** The Chair stated that this paper should be received for assurance not information and the coversheet needs to be amended. **QS20/88.2** The Chair queried the chart on page 3 of the report and requested explanation of the reporting mechanism for the SSNAP scores within the table. The Director of Performance advised that SSNAP scores range from A – E which provide an indication of where the service is in relation to the 10 essential evidence based criteria for stroke services, these are reported quarterly. A indicates the highest score and E the lowest that the service can achieve. It was noted that the 10 elements have multiple measures to get an overall service score, BCUHB had predominantly scored D which had more recently improved to B and C levels which does vary each quarter.	

QS20/88.3 An Independent Member referred to a business case that was submitted to Finance & Performance Committee in November 2019 and queried progress since then. The Director of Performance advised that at that time no income stream was available to support the investment proposed, however, this was prioritised for 2020-21 to enable delivery of an early supported discharge hub and it was noted that some improvements have since been made without full investment. Whilst resource allocation has been confirmed for this year, for year 1 of the business case, COVID has since impacted on final process and a decision is still awaited. Clarity was required of whether investment is going to take place to enable year 1 of implementation plan. **QS20/88.4** An Independent Member referred to the stroke rehabilitation ward in Wrexham that is reported to have been identified for surge capacity but is not currently needed for that purpose. As stroke rehabilitation is an identified essential service, is this ward going to be reallocated. It was confirmed that this is being reviewed at the clinical pathways group. **QS20/88.5** The Chair queried why YGC is an outlier in relation to mortality but is scoring higher on SSNAP score overall. The Director of Performance explained that mortality rate is not one of the indicators underneath the SNAPP score, which are more process indicators rather than outcome indicators. It was also noted that a mortality action plan is in place with a clinical lead to review improvements in mortality. **QS20/88.6** The Director of Performance advised that directive had been received that performance reporting has formally been stepped down nationally but that local reporting continues. **It was resolved that** the Committee receive the report for assurance.	**JN**
QS20/89 Ophthalmology Report **QS20/89.1** The Chair stated that this paper should be received for assurance not information and the coversheet needs to be amended. The Chair invited questions from members. **QS20/89.2** An Independent Member queried benefit realisation for the eye-care transformation funding for 2019/20. It was noted that there were specific schemes within the funding which included setting the direction for primary care based services. This was deemed another important example of services that need to continue as essential work. **QS20/89.3** The Chair referred to the table on page 5 and requested clarification of how many patients are categorised as high risk factor 1. The Director of Performance advised that there are specific measures through outpatient and eye care transformation workstreams which aim to reduce risk to patients and the number of patients that were 100% overdue follow up appointments. It was noted that whilst the year end position was achieved and significant improvement made on last year, there are still a considerable volume of overdue patients.	

QS20/89.4 The Director of Performance confirmed that 83% of eyecare patients are classified as high risk patient, within these the number overdue are still significant which presents clinical risk. Risk stratification process is being used to identify patients needing to be seen within 12 weeks (red), 5-12 weeks (amber) and 12 weeks and beyond (green). Table top review undertaken indicated 70% of patients, not at risk at present moment and can be safely managed with a deferral period of 12 weeks and 10% not classified as red can be managed on urgent care pathway with optometrist to ensure reducing potential risk of harm. It was noted however that not all patients have had a table top review yet and work is ongoing to review those postponed or due to be booked. **QS20/89.5** The Executive Director of Nursing and Midwifery stated that there is a need to understand what is being done as part of the table top exercise and how risks are being mitigated. The Chair expressed concern regarding risks and terminology throughout paper and requested more analysis and risk assessment and will discuss specific requirements with the Director of Performance outside the meeting. **It was resolved that** the Committee receive the report and feedback provided would be actioned.	
QS20/90 Psychological Therapies Report *Mrs L Singleton in attendance for this item* **QS20/90.1** The Chair referred to the psychological therapies work programme set out on page 2 that included the scope of the workstreams being linked to the recommendations to make it easy to see how they were being addressed. **QS20/90.2** The Interim Director of Mental Health stated that phase 2 of COVID planning is reviewing how to step work back up to business as usual. **QS20/90.3** It was also noted that the Chair and Interim Director of Mental Health had had discussions about the wellbeing hubs and whether the use of volunteers could be considered as a resource to enhance iCAN related support. The Interim Director of Mental Health confirmed that discussions have taken place with workforce to ascertain whether staff are interested in doing ICAN training to build up additional capacity from staff support perspective and service users. JH confirmed she is part of the wellbeing group and that discussions were underway with Alice Cole-King to review further support for staff. **QS20/90.4** The Executive Director of Nursing and Midwifery also advised that the safeguarding team are also providing support to staff. **QS20/90.5** An Independent Member stated that there is a range of support materials circulated around the organisation but suggested that these are co-ordinated in one place. The Interim Director of Mental Health agreed to review this. **It was resolved that** the Committee receive the report	

QS20/91 BCUHB Obstetric Haemorrhage rates report and action plan

Mrs Fiona Giraud in attendance for this item

QS20/91.1 The Director of Midwifery and Women's Services advised that the paper had been prepared by Mr Hemant Miraj NW Clinical Lead for Women's services who is leading on the improvement plan in response to the service being identified as an outlier with the highest post-partum haemorrhage (PPH) rates in Wales. It was noted that during the first 3 months of 2020 there has been a significant reduction in PPH of 1000 mls but the service currently remains an outlier for 2500ml PPH rates.

QS20/91.2 The Director of Midwifery and Women's Services advised that Health Boards across Wales are working together to reduce harm from PPH and care provided to women through a series of improvement steps to reduce overall PPH rates across Wales. The Director of Midwifery and Women's Services also advised that an MDT meet locally including anaesthetics and midwifes to review local actions and monitor PPH rate included on monthly dashboard.

QS20/91.3 The Director of Midwifery and Women's Services also advised that there had been a change in clinical practice in the use of drugs from Syntocinon to Syntometrine as the first line prophylactic uterotonic for the management of 3rd stage of labour for any risk factors for PPH. This was in line with the NICE guidance.

QS20/91.4 An Independent Member queried whether there are more high risk patients than any other health boards or are figures based on a mitigated risk basis. The Director of Midwifery and Women's Services stated that there is concern for the number of 2500ml PPH in relation to morbidly adherent placenta and a study is being undertaken and will be compared with rest of Wales.

QS20/91.5 An Independent Member queried how serious a problem this is in relation to impact and consequences compared to the rest of the UK. The Director of Midwifery and Women's Services confirmed that the NMPA team identified BCUHB as an outlier in Wales and the UK.

QS20/91.6 The Director of Midwifery and Women's Services advised of the introduction of all the Wales procedure and pathway point of care testing to reduce morbidity and mortality rates which triggers the pathway for management of PPH.

QS20/91.7 The Director of Performance queried if there was variation between sites in terms of the outlier status and it was noted that there is no considerable variation across the 3 sites, although there has been minimal reduction in the rates of PPH rate >2500ml in the Wrexham sites compared to other sites but no significant variation.

QS20/91.8 The Chair requested clarification on how implementation of the revised approach will be monitored and it was noted that this will be monthly in view of PPH levels, all datix are reviewed within 72 hours and weekly PTR and dashboard split per areas / trauma. The Womens subcommittee meeting bi-monthly as an MDT to monitor changes, impact and outcomes as a consequence of changes in practice.

It was resolved that the Committee receive the report.

QS20/92 Response to HIW review of maternity services **QS20/92.1** The Chair referred to the sentence on page 2 regarding plans to interview key personnel to present evidence to support phase 3 of the governance from ward to board for phase 3 of maternity review had been postponed due to COVID and will be picked up as COVID arrangements reduce. HIW will produce an interim position statement and share CHC feedback on Women's services so health boards can work with elements of feedback of governance and feedback. **QS20/92.2** The Chair referred to a number of areas still in progress relating to procedures including CTG training which frequently features in birth related claims and queried what is being done to mitigate risks. The Director of Midwifery and Women's services advised that each individual practitioner is required to undertake 6 hours of face to face training, as stipulated by WG, to be compliant. Weekly CTG training sessions have been set up for labour wards at each DGH for acute and community staff to attend. Figures at the end March reported 89% compliance with CTG training, however, COVID-19 arrangements have impacted on the ability to train face to face and alternative training methods are being explored to support social distancing. **QS20/92.3** The Executive Director of Nursing and Midwifery emphasised the importance of identifying actions and supported the stance being taken to mitigate risk and this can be amended as appropriate if WG advise differently. **QS20/92.4** The Chair queried what our compliance with policies was and it was noted that this was 72% compliant with policies from the Welsh Risk Pool, however, it was clarified that whilst all policies are in place for maternity, some of these are currently under review. It was also confirmed that the Obstetricians review and update policies and pathways on a monthly basis as part of an assurance framework similar to RCOG process. New pathways have also been prepared to present and support services and clinical pathways throughout COVID which have superseded some existing policies. **It was resolved that** the Committee receive the report.	
QS20/93 Maternity Framework for maintaining life-saving and life impacting essential services during the COVID-19 pandemic **QS20/.93.1** An Independent Member referred to newborn screening for hearing and queried the process for women who plan a home birth which in the current COVID circumstances could delay screening for hearing. The Director of Midwifery and Women's Services advised that Screening Wales supports screeners to undertake screening in hospital and it is a national concern for deliveries outside of the acute setting might have to wait up to 9 months and this has been raised as a risk in relation to potential developmental issues. It was noted that alternative pathways are being reviewed to look at how to monitor and screen babies born outside of acute hospital. **QS20/.93.2** The Committee acknowledged the efforts made to successfully relocate services away from acute sites. **QS20/.93.3** The Chair made reference to the Health Board not being able to support home births in the current climate mentioned in the report. The Director of Midwifery	

and Women's Services advised that there are two elements to the discussion around home births during the pandemic, firstly in terms of staffing there has been a reduction in the number of community midwives with 10% of the workforce absent due to COVID restrictions / shielding which presents a challenge to maintain services and a home birth service which requires 2 midwives present. Secondly, the impact on the provision of emergency transfers by WAST from community settings was also a restricting factor. It was confirmed that the whole service provision continues to be reviewed and updated position from WAST is awaited on the ability to support transfers. **QS20/.93.4** The Director of Midwifery and Women's Services advised that expectant mothers are informed of the impact in having a normal home birth service currently and risk assessments were undertaken on an individual basis to help them make an informed choice. The CHC has also been informed of the position regarding midwifery services. **QS20/.93.5** The Chair referred to the request for the Committee within the recommendations to make a decision to support ring fencing of red and green estate adaptations on all 3 DGH and relocated services in the communities. It was noted that this has been reviewed at the clinical pathways group which was endorsed for Women's services but that the Committee had not been sighted on this for other services. An action was agreed for the Executive Director of Nursing and Midwifery and the Executive Medical Director to present the clinical element of pathways to QSE so the committee is sighted on the level of risk associated including essential services and to ensure governance processes. **It was resolved that** the Committee receive the report.	**GH/DF**
QS20/94 Corporate Risk Assurance Framework **QS20/94.1** the Chair referred to a number of concerns which would be circulated to members outside the meeting. This included clarity of a clear audit trail for scrutiny of updates and changes to risks and clarity of scoring for risk descriptions where controls had been strengthened. Reference was also made to the care homes risk now posing a different, higher risk within the current pandemic. **QS20/94.2** The Executive Director of Nursing and Midwifery advised that it had been agreed to separate out the risks to ensure scrutiny of the corporate risk register, noting those that are COVID related or not and the importance of ensuring that all risks are scrutinised in the same way as in normal business. As a consequence of COVID, care homes have become an increased risk which is being reviewed. **QS20/94.3** The Interim Associate Director of Quality Assurance advised that a review of the corporate risk register will take place regularly at QSG meetings prior as well as review by executive leads particularly for risk scores which date back to 2013. **QS20/94.4** An Independent Member referred to CRR21 risk for Health and Safety which did not include any reference to working with trade unions which appeared to be an omission. **It was resolved that** the Committee received the report and feedback provided would be actioned.	**LR**

QS20/95 Ward Accreditation update **QS20/95.1** The Committee noted that the report provided a better understanding of hotspots across the Health Board. **QS20/95.2** An Independent Member referred to the figures produced in percentages for the number of wards having been assessed and was unclear from this how many wards have not yet been assessed. **QS20/95.3** The Executive Director of Nursing and Midwifery advised that the majority of secondary care wards have now been accredited. The findings from the assessments are now being triangulated with other information to identify triggers for wards to be reassessed within normal reassessment period to provide assurance. **QS20/95.4** It was also confirmed that Paediatrics are undertaking work to deliver improvements which will be reviewed alongside other relevant data to support the accreditation and ensure it is aligned to the improvement trajectory. **QS20/95.5** An Independent Member highlighted the 27% of white wards were within YGC and it was noted that whilst there had been a number of improvement processes, this is being further reviewed and triangulated with other data to ensure improvements are delivered. **QS20/95.6** The Executive Director of Nursing and Midwifery advised that work is underway to consider how to present the data in a more co-ordinated way, aligning to the IQPR. **QS20/95.7** An Independent Member stated that the report provided an overview of the excellent work done and highlighted the need to build on sharing learning as well as identify gaps, ensuring that data is being triangulated and consider how best to provide the appropriate assurance to QSE and Board. It was agreed that the Chair will liaise with other Independent Members prior to meeting with the Executive Director of Nursing and Midwifery. **It was resolved that** the Committee received the report and feedback provided would be actioned.	**LR**
QS20/96 Health & Safety Update Report **QS20/96.1** An Independent Member referred to the bullet points within section 2, incident reporting and suggested these needed to be clearer. The Interim Director of Quality Assurance confirmed that the first bullet point referred to incidents being captured for staff members whom have tested positive, where it is reasonably believed that the transmission, was work related, but the 2nd and 3rd bullet points relate to any circumstances and it was agreed to reword the third bullet point to 'death attributed to COVID' to be more explicit. An Independent Member also requested that the final sentence on page 3 be reworded about staff who have tested positive.	**MJ** **MJ**

QS20/96.2 The Interim Director of Quality Assurance advised that the paper had been written based on national work and would feed above comments back to the national team. **It was resolved that** the Committee received the report.	
QS20/97 QSE Committee Annual Report **QS20/97.1** The Chair asked if members were content with the level of assurances set out within section 6. **QS20/97.2** An Independent Member referred to the patient experience objective and queried the red status given the significant amount of work undertaken. The Executive Director of Nursing and Midwifery advised that a number of processes are in place and conversations are ongoing regarding patient experience reports and ensuring that these sufficiently address the issues to provide assurance of work undertaken. It was agreed that the narrative would be amended to make it clearer that improvements are in process to gain patient feedback and collate information and data but focus is required to use this more effectively to provide assurance that work is progressing. **QS20/97.3** The Interim Director of Quality Assurance confirmed that whilst improvements had been made a number of targets were still not being met and further work is required to deliver improvements in response to complaints and ensure learning. **QS20/97.4** An Independent Member referred to the risk on the corporate risk register (05) related to the lack of learning from patient experience and there was a discussion regarding the risk score and the need to measure impact and likelihood of risk occurring versus improving patient experience. **QS20/97.5** The Committee acknowledged the significant work that had been undertaken to improve patient experience, particularly the changes in the PALS, but that the focus now needed was to ensure that the relevant data is used effectively to secure improvement so that the Committee could be assured. **QS20/97.6** The Chair referred to section 4 of the report regarding attendance and advised that a sentence needed to be added to reflect the technical difficulties thatprohibited Cllr Cheryl Carlisle's attendance on 17th March despite several attempts. **QS20/97.7** The Chair also advised that page 13 in relation to the focus for the year ahead will need to amended as this was written prior to the pandemic and she agreed to circulate additional proposed wording for review. The cycle of business will also be revisited. **It was resolved that** the Committee received the report and feedback provided would be actioned.	**CB / KP** **LR**

QS20/99 GMS Access Standards **QS20/99.1** No issues were raised following review the report **It was resolved that** the committee received the report.	
Date of Next Meeting – **Friday 3rd July 2020**	
Exclusion of Press and Public **It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.'	

BCUHB QUALITY, SAFETY& EXPERIENCE SUB COMMITTEE - Summary Action Log Public Version				
Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
21st May 2019				
D Carter	**QS19/70.2** Consider whether non-patient elements need separating from the CLIICH report in terms of category 'abuse of staff by patients', for next submission	Sept	24.9.19 discussions between teams ongoing as part of gap analysis. 30.10.19 The new Assistant Director of Service User Experience (who started with BCU in mid-October) is meeting with the Assistant Director of Health, Safety and Equality and will discuss how patient safety and staff safety incidents will be separated in the reports submitted to the committee, ensuring information to the committee is not lost and remains triangulated where appropriate. 19.11.19 The Chair confirmed she had met with the new Assistant Director for Patient Safety and this action would be addressed within the Patient Safety report in January. 28.1.20 The Committee were content that this action could be closed.	January Closed
~~E Moore~~ M Maxwell	**QS19/74.2** Reflect on comments regarding format and flow of mortality report including the need to ensure a single author/owner for next submission.	Sept	17.9.19 A revised format has been submitted and agreed at Quality Safety Group, and will inform the next report to Committee. 24.9.19 Committee agreed to re-open the action until next mortality report received. 12.11.19 Mortality report agendered for discussion at November Committee meeting. Members' feedback invited on format and flow. 19.11.19 Further report requested for January. Meeting set up for January between QSE Chair and Office of Medical Director.	~~Closed~~ ~~November~~ ~~January~~

			6.1.20 Meeting held and clarification/steer provided on how to improve and strengthen mortality reporting, with agreement the paper be deferred to the March meeting. 28.1.20 QSE Chair confirmed her expectation that the paper in March will be a plan of action as to how mortality will be addressed and reported. 04.03.20 A plan for the development of mortality reporting was submitted to the March meeting Update: item deferred 10.06.20: Action was deferred due to Covid 19 pandemic. Stage 1 have continued to be completed and some Stage 2 reviews. Meeting planned with sites and also community / primary care / MHLD to review process to extract learning. ME posts currently being advertised – this role will include part 1 review and direction on the need for further investigation internally.	March
16th July 2019				
D Carter	**QS19/99.2** Include patient story re Welsh Language in the next Welsh Language monitoring report		13.9.19 As recommended by QSE, Head of Patient and Service User Experience for BCUHB has produced a Quality Assurance for Patient Stories Framework Sept 2019 to ensure that all Patient Stories are monitored. BCUHB has ensured adequate resources are in place to sustain the growth and development in capturing, monitoring and measuring quality improvements from patient stories. The Listening and Learning group will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. The Listening and Learning Strategic forum for Patient and Service	~~Closed~~

			Experience' group (LLG) (LLE was stepped down for 6 months to review the function/purpose of the meetings and capture the correct attendees in alignment with QSE and QSG). The LLG will focus on outlining targets and reporting frameworks to link the connections between Patient & Service User feedback and service improvements. The LLG will be the quality assurance measure to monitor reports and translate them into improvement work and celebrating best practice. This includes Patient Stories. Patient Stories will be integrated into the Clinical Harm Dashboard along with all other feedback methods. Quality improvement actions will be captured, monitored and measured in triangulation with incidents and complaints. The one system approach strengthens the service improvement management. 24.9.19 Committee requested action be re-opened as response did not confirm if the patient story had been included into the Welsh Language monitoring report or not. 19.11.19 Noted that the qualitative report re Welsh Language came to QSE as part of the IQPR reporting process. Timeframe for next report to be confirmed and whether the patient story had been included. 28.1.20 The Committee were content that this action be closed.	November January Closed
C Stockport Lucy Reid	**QS19/102.2** Work to provide a heat map summary in future primary care reports	By next report (March)	Summary provided in the primary care report for March QSE 17.03.20 LR to discuss level of detail of practice sustainability information with CS	TBC following COVID-19

C Stockport	**QS19/102.4** Ensure that future reports include narrative on lessons learned from incidents	By next report (March)	Detail of how 'lessons learnt' are collated and shared with Primary Care colleagues is included in the report for March QSE. To remain open as item was deferred 05.05.20 revised IQPR format will include primary care measures going forward	TBC following COVID-19
A Thomas	**QS19/112.3** Follow up query from the May QSG report as to whether the related patient safety alert had been closed at the time, even though a Medical Devices Safety Officer was not in post.	Sept	24.9.19 AT reported that there was a lack of clarity. The CHC Chair accepted that the information was difficult to unpick retrospectively but was assured that the intention to appoint a Medical Devices Safety Officer was still ongoing. Committee agreed to keep action open. 19.11.19 AT confirmed there was a robust system around medical devices and this was an operational issue that should back through QSG, however, the Chair reminded members that the action had originated from the report from QSG. AT would take this action away again. 20.1.20. AT has had confirmation from the DGM of NWMCS that the MDSO function will be assigned to a member of staff within the Medical Devices team by the end of June 2020. 28.1.20 The Committee were assured that day to day work continued whilst the nominated MDSO function was ongoing, and that tracking was undertaken via the Assistant Director Patient Experience. The Committee were content that the action be closed.	November January Closed
24th September 2019				
J Newman	**QS19/129.1** Revisit the briefing note (against action QS19/101.1) on mapping of indicators to	Oct	19.11.19 JN indicated that there was a list within the IQPR of annual plan issues that came through QSE. The Chair reiterated that the action relates to having	

	reflect members' comments re appropriateness and mapping to SPPH		the briefing note refreshed to give the Committee confidence that it was monitoring the right annual plan elements. JN set out challenges in that whilst an overall action may be attributed to QSE there may be multiple milestones within that action which relate to another Committee – for example clinical coding. SG felt that an action shouldn't need to be deconstructed in order for it to be fully monitored. It was suggested that the Executive Director of Planning & Performance take the discussion through Exec Team. 28.1.20 The Chair of QSE has discussed this with the Executive Director of Planning and Performance. The committee with overall responsibility to scrutinise each Action in the operational plan will be added to the IQPR from the next report. This will reflect that some of the actions are being scrutinised through committees over than QSE.	January Closed
D Carter T Owen	**QS19/139.1** Ensure that next report from Women's Division includes detail of the reported clinical complex cases.		19.11.19 TO suggested that six months would be appropriate for next report. 05.05.20 Reports presented to May committee meeting	Closed
19th November 2019				
J Newman	**QS19/164.1** Review the sequencing and reporting of APMR reports to committee to ensure as timely as possible.	January	28.1.20 Review took place immediately after the QSE meeting resulting in timetable for report completion being brought forward. Updates from Executives are now requested at month end to enable earlier sign off of the report by the Exec Team. The completed report is issued to all relevant secretaries of the Board Committees so as to enable the latest report to be included in next Committee	Closed

			meeting and for QSE members to receive reports relating to month end progress during the months that the committee does not meet.	
L Singleton	**QS19/165.3** Ensure that future MHLDS exception reports within IQPR provided an explanatory narrative where a major outlier was identified, together with timelines to address.	January	21.1.20 S Forsyth confirmed this has been taken on board and actioned. 28.1.20 The QSE Chair did not feel the narrative sufficiently set out the current position and asked that this action be reopened. 09.03.20 comments in relation to the IQPR have been acknowledged and work is underway with Head of Ops to improve narrative which will be completed for future reports.	TBC following COVID-19
J Newman Mark Wilkinson Lucy Reid	**QS19/165.5** Consider reviewing an existing performance team reporting schedule to include information for committee members as to what data goes where and when	January	28.1.20 Director of Performance confirmed this had been actioned and she would provide the necessary narrative to enable the action to be closed 28.1.20.The list of when each measure is reported and the committee reported to was circulated to members ahead of the January 2020 QSE meeting by the committee secretary 17.03.20 LR to discuss further with JN and MW 05.05.20 IQPR is being redesigned to fit with quadruple aim healthier wales as part of the new national framework. The list of which indicator is sent to which committee was submitted ahead of the January QSE. The revised Annual Delivery Framework has now been issued and the indicators within this reflect the Quadruple Aim. Given the pandemic, national performance reporting was stood down in March. This is being reinstated in June with information being submitted for management information rather than performance. Internally the majority of	

			indicators have continued to be reported and the IQPR redesigned to provide this information to Committees aligned to the Annual Plan Delivery framework and the role of each of the Board Committees. The Board Committees will also receive the quarterly operational plan monitoring report. The Q2 operational plan actions will include the requirements of the Annual Delivery Framework. In June the Committee will receive both the Quality and Performance Report in its revised format and the Q1 operational plan monitoring report.	
D Fearnley	**QS19/171.2** Look at uptake against safeguarding training within various staff groups and provide a briefing note for circulation outside of the meeting.	January	19.1.20 Site Medical Directors have been asked to review safeguarding training for medical staff and report performance to the Executive Medical Director before end of January 2020. A briefing note will then be circulated to QSE members. 28.1.20 The Executive Medical Director confirmed this related to EDs and he would ensure the outstanding briefing note was circulated before the next meeting 09.03.20 Briefing note circulated	Closed
M Denwood	**QS19/171.3** Provide details of referrals by both area and referrer in future reports.	May 2020	This information is collated within the safeguarding Data profile and will be reported by exception within the Annual Report	TBC following COVID-19
M Denwood	**QS19/171.3** Work to ensure future reports are less numbers-focused and concentrate more on outcomes and learning.	May 2020	A clearer analysis of any data, to provide assurance and evidence of mitigation will be reported by exception within the Annual Report	TBC following COVID-19
L Reid	**QS19/175.1**	December	20.1.20 Committee Chair has drafted correspondence	Closed

	Send a letter of congratulations on Nursing Time award for Team of the Year to the MHDLS Division		28.1.20 The QSE Chair confirmed this had been action. Point was raised that there were numerous other awards that could be recognised similarly. Noted that these were acknowledged directly at Executive level.	
D Carter	**QS19/180.4** Arrange for amendments to be made to the Levels of Enhanced Care In-Patients Policy for submission for Chair's Action	December	21.1.20 revised policy received and will be submitted to Chair for approval 06.02.20 policy submitted to Chair for approval	Closed
D Carter	**QS19/182.1** Work to refresh the HASCAS / Ockenden reports to ensure more manageable	January	Refreshed report submitted for January meeting	Closed
28th January 2020				
L Singleton	**QS20/4.3** It was noted that a briefing note on suicides had been circulated to members, although the Chair expressed concern that it did not provide a thematic review of the cluster of suicides within the West and asked that this be re-provided for the March meeting.	March	Report submitted for discussion at March meeting	Closed
D Carter	**QS20/7.1** Circulate briefing note already prepared on awards and achievements.	February	Deferred until further notice during revised COVID-19 pandemic arrangements in place	TBC following COVID-19
L Reid	**QS20/7.1** Discuss with the Health Board Chair the potential of sharing information on awards and achievements at Board meetings.	February	This has been discussed with the Chair as part of the Board development programme	Closed
Jill Newman	**QS20/8.1** Link APMR reports to other committees	March	09.03.20 The APMR has been amended to include an additional column to show which committee has responsibility for scrutinising which action	Closed

Jill Newman	**QS20/8.2** Amend reports to remove 'no update' and ensure accuracy in reporting	March	09.03.20 The narrative has been refined to ensure there is a distinction between 'no update being received from the sponsor', and 'no further progress on implementation of the action' to provide greater clarity.	Closed
Jill Newman Mark Wilkinson Lucy Reid	**QS20/9.1** ensure narrative in IQPR reports links to previous reporting	March	09.03.20 Retrospective lookback on a sample of reports commenced and will be completed for the May report 17.03.20 LR to discuss further with JN and MW 05.05.20 IQPR is being redesigned to fit with quadruple aim healthier wales as part of the new national framework. Look back work has been undertaken, review of this report has been delayed due to Covid-19 and staff absences and can be presented as learning at the August committee meeting to close this action at that point. The report has been redesigned.	
T Owen Jackie Hughes	**QS20/9.5** Follow up maternity staffing issues to ensure transparency of reporting and sharing of information with Trade Union partners.	March	Compliance is reported at the annual WG Maternity Performance Board and submitted to HIW as part of their Review of Maternity Services. The current full Birth Rate Plus audit is being carried out by the Birth Rate Plus Consultancy Team and final report is awaited. The 2016/17 report has been shared with the local RCM Representative and a meeting is scheduled (in the next week) to explore/discuss the report further. Finalised report will be reported via the Women's Committee/Meeting Structure. The Head of Service meets with RCM Representatives regularly, and will brief all IMs as appropriate.	Closed

			17.03.20 JH to discuss ongoing concerns with TO and GH 05.05.20 discussions with TO confirmed the issues raised by the Trade Union representative had been addressed.	
L Singleton	**QS20/9.6** Provide paper on psychological therapies update to next meeting including the terms of reference for the Psychological Therapies Programme Board.	March	Report submitted for the March meeting	Closed
J Newman	**QS20/9.7** Briefing note to be circulated In relation to postponed procedures, which focused on the specified non-clinical reasons.	March	09.03.20 Included as additional slides in the IQPR for March 2020 17.03.20 LR to discuss further with JN and MW 05.05.20 an update on essential services to be presented to QSE July meeting Essential service report included on July Agenda in addition to the original request for postponed procedures.	July
Sue Green	**QS20/11.2** Provide an update on the exploration of a contracted solution for the Occupational Health Physician vacant post	March	Two Occupational Health Physicians (OHP) have expressed an interest for the OHP post within the Occupational Health and Wellbeing Department. Interviews are planned for early May 2020. It is anticipated the post will be filled by September 2020.	Closed
D Carter J Newman M Maxwell M Joyes	**QS20/12.3** Meet to discuss how more consistent data reporting could be achieved across various department from different software packages and systems.	May	Work in progress – further update to be provided 05.05.20 discussions are ongoing in relation to standardising the presentation of graphical information in the use of SPC charts across the Health Board. SPC tools have been shared however the Health Board standard has not yet been established due to a range of products currently in use. Further update to be presented to August meeting	

D Carter M Joyes	**QS20/12.4** incident reporting to be expanded to include the highest incident categories rather than just reporting on the top 3	March	SI report updated to include all themes – report submitted to March meeting	Closed
L Singleton	**QS20/13.2** Work to develop increased visibility around actual lessons learnt for the next routine report from the MHLDS Division.	May	09.03.20 Work is underway to include lessons learnt within May report	TBC following COVID-19
M Joyes	**QS20/16.1** Provide action plan against the All-Wales Self-Assessment of Quality Governance Arrangements at next meeting	March	Deferred until further notice during revised COVID-19 pandemic arrangements in place	TBC following COVID-19
D Carter	**QS20/17.2** Continue to provide full inspections reports as part of HIW updates	March	Reports submitted for information at March meeting	Closed
L Singleton	**QS20/18.1** Refresh risk description for CRR13 Mental Health	February	Refreshed narrative will be presented at the Risk Management Group Meeting in May 05.05.20 risk description confirmed as having been updated	Closed
S Green	**QS20/18.2** Provide target date for ID 3024 Non-Compliance of Fire Safety	February	17.02.20 Target risk date for ID 3024 Non-Compliance of Fire Safety has been set to 01/11/2020.	Closed
S Green	**QS20/18.2** Change "comprise" to "compromise" on ID 2956 Potential to comprise patient safety due to large backlog and lack of follow-up capacity	February	11.2.20 Workforce Optimisation Business Manager / Programme Manager contacted Datix support to enact this change. Completed. 17.02.20 Wording "comprise" has been amended to "compromise" on ID 2956	Closed
G Harris C Stockport	**QS20/18.3** Refresh risk description for ID 2950 Potential inability of Care Homes to provide safe quality care	February	The Risk Description ID 2950 has been de-escalated and reviewed in line with discussions at the previous meeting and the risk now states *…."The ability of the Health Board to respond proactively to support care homes when concerns are raised".*	Closed
L Meadows	**QS20/18.4** Raise issue of IMs input into H&S risks – via next IMs meeting	March	09.03.20 LM emphasising the importance of health and safety to IMs	Closed

L Reid	**QS20/20.4** Escalate quality, safety and strategic aspects of the General Medical Council Enhanced Monitoring of Medicine Training and Wrexham Maelor Hospital**,** to the Board through Chair's report.	March	This has been discussed with the Chair and a report has been requested for the March Board meeting.	Closed
G Harris	**QS20/21.1.1** Further amend and submit Review of Open Visiting Policy for Chair's action	February	09.03.20 Executive Director of Nursing seeking assurance that the Visitors Charter, appendix to the Open Visiting Policy, is being reviewed with wider stakeholders prior to Chairs Action. 02.04.20 The updated visitors' charter will be sent back to the CHC for further review following COVID restrictions. 05.05.20 confirmation that the visiting policy has been updated further in line with WG guidance	Closed
G Harris	**QS20/21.2.2** Add W&OD colleagues' comments to Nurse Staffing Levels Policy and resubmit for approval under Chair's Action	February	WOD colleagues confirmed they had not previously commented on the policy during consultation period. Comments have now been received, added and forwarded 10/02/20 for policy final ratification	Closed
M Maxwell	**QS20/21.3.1** Amend frequency of reporting within the clinical audit policy	February	Reporting amended quarterly to CAESG and annually to JAQS	Closed
K Dunn	**QS20/21.4.1** Arrange for discussion around submission of policies at next CBMG and invite Bethan Wassell.	March	5.5.20 Invitation sent to Bethan Wassell, and notification to CBMG secretariat to include on March agenda.	Closed
17th March 2020				
G Harris	**QS20/47.2** further details to be provided in relation to the number of 'unavoidable' infections	May	Avoidable infections are those whereby the infection should not have occurred. These may be in relation to health care, device care and/or exposure to an organism in the environment. Avoidable infections reduced over Q1 and Q2 with innovations and deep dive analysis. However it is expected to achieve a position where avoidable infections are	

			minimal/zero and any occurrence is reported by exception. (e.g. 79 infections in January of which 61 (77%) were unavoidable, issues include contaminated blood cultures, catheter infections, relapse and attributable to another Trust. 05.05.20 – further update requested see action QS20/85.3 below	
G Harris	**QS20/27.5** provide further details on the difficulties in cleaning the environment on Ward 19 referred to within the report	May	Ward 19 experiences the most outbreaks of infection in the Health Board, and is the most difficult to terminally clean. It is not possible to HPV the ward due to ceiling voids and square footage. In addition the two rooms available are not en-suite and one is at the end of a bay. There is a toilet shared between 2 bays that opens out onto the reception area of the ward. Ward 19 is still waiting to move to Ward 2. During April 2020 whilst COVID 19 is occurring Ward 19 has had a further Norovirus outbreak. 05.05.20 – further update requested see action QS20/85.8 below	
G Harris	**QS20/27.6** Provide details on how domestic cleaning standards will be maintained during the COVID-19 pandemic given pending pressures and additional risks faced.	May	Cleaning continues in the same way as before due to the products used which destroy COVID 19 in the environment. As with all “periods of Increased Incidence (PPI)”, enhanced cleaning takes place in high activity areas whereby touch points, hand decontamination resources and waste are addressed three times a day rather than twice.	Action to be closed
G Harris	**QS20/27.7** revise Ward Accreditation reports to ensure split by site / area	May	Report to May meeting addresses this requirement 05.05.20 members satisfied action had been addressed within report presented	Action to be closed

G Harris	**QS20/50.1** clarify details of operational issues between BCUHB and WAST referred to in the WAST handover at ED report.	May	A revised 'dual pin' handover procedure was implemented in July 2019 whereby both nursing and ambulance staff jointly enter a unique pin to release the vehicle within 15 minutes of arrival and immediately at handover. Since this process was implemented there has been a deterioration in the 15 minute ambulance handover performance for the Health Board and the effectiveness of this process is under review on an All Wales approach. This is being addressed through the Emergency Department Quality Delivery Framework (EDQDF), of which BCUHB are an early adopter, and ambulance handover improvement is one of the key priority areas. 05.05.20 members requested an update on the dual pin process Update – sites have identified actions to ensure safe and effective handovers and to reduce handover delays. Some behavioural issues were acknowledged alongside other challenges in the dual pin process, which is reliant upon ambulance crews entering PIN promptly prior to HB staff. A number of actions have been taken within departments to support and facilitate the process including nurses booking patients in at reception instead of crews; extra entry points into the site, and operational managers encouraging crews in prompt PIN entry. Sites remain in regular contact with WAST to support ongoing improvements and address any operational issues.	Action to be closed

L Singleton	**QS20/56.1** Amend summary action plan for the psychological therapy services report to reflect the recommendations from the review	May	Report to May meeting addresses this requirement 05.05.20 members satisfied action had been addressed within report presented	Closed
L Singleton	**QS20/56.1** Update the membership for the Terms of Reference for the psychological therapy services review group	May	Report to May meeting addresses this requirement 05.05.20 members satisfied action had been addressed within report presented	Closed
5th May 2020				
G Harris L Reid	**QS20/82.5** Review the length of time papers are to be deferred and discuss in line with any plans to return to normal business reporting arrangements.	July	This is to be discussed at CBMG on 18th June 2020	
G Harris	**QS20/82.6** Circulate paper detailing interim governance arrangements for Board and Committees.	May	Circulated to members 07.05.2020	Action to be closed
G Harris M Denwood	**QS20/82.7** Safeguarding report to be presented to the next QSE Committee.	July	Agenda item QS20/113	Action to be closed
C Brennan	**QS20/82.8** Circulate IQPR report prepared for QSE members to be circulated	May	Circulated to members 05.05.2020	Action to be closed
G Harris A Miskell	**QS20/85.3** Further to response to previous query QS20/47.2 re unavoidable infections, further query raised as to what actions are being taken to reduce infections and also clarify details regarding catheter infections following challenge that these infections are classed as unavoidable.	July	Avoidable infections are those whereby the infection should not have occurred. These may be in relation to health care, device care and/or exposure to an organism in the environment. Avoidable infections reduced over 2019/20. Innovations and changes to address some of the avoidable infections included: • Continued ANNT training • New vascular device document which is more user friendly and prioritises the VIP score, which may indicate and infection • Review of catheter passport • All inpatient audit to review rationale for catheterisation	Action to be closed

			• Nov 2019, a “just in case” initiative to prevent unnecessary use and removal of vascular and urinary devices • Collaborative work with WAST re insertion of red/green devices to indicate if device was inserted under ANTT or not. Avoidables also include contaminated blood cultures, although they are not true infections they are included in the trajectory figures. Unavoidable infections still include some blood stream infections that may be device related. Examples have included: • Intravenous drug users • Non-compliance with device care (both vascular and urinary) in the home • Those patients who require a device but are a chronic carrier of an organism	
G Harris A Miskell	**QS20/85.4** Clarify triangulation of urology data with removal of catheters and confirm details of work programme.	July	From the catheter audit carried out across inpatient beds, we learnt that trail without catheters (TWOCs) was not necessarily taking place as frequently as it could be. Daily review of devices was launched in November 2020 as part of safe clean care and a need to reinvigorate device management. A community audit across the continence and district nursing teams was planned for Spring 2020, but this has had to be postponed. Some patients with catheters were awaiting Trans urethral resection of the prostate (TURP), and some patients catheterised in ED for acute retention were reliant	

			on Urology day care services for TWOC as there is no formal TWOC service in the community. IPC would want to commence the community review as soon as able.	
G Harris A Miskell	**QS20/85.5** Clarify details of infections attributable to other trusts / organisations are discussed with the organisation concerned.	July	Yes. This is triangulated with performance and contracts. IPC review the post infection reviews.	Action to be closed
M Joyes	**QS20/85.6** Outcomes of learning review held 1st May from issues arising at Ruthin & Holywell community hospitals to be shared as a matter of urgency via infection prevention and area teams across all other areas including primary care and care homes.	July	Infection control reviewed have been completed for both outbreaks and lessons shared via IPC Teams. The IPC Team continue to be involved in tracking cases and outbreaks and supporting local reviews.	Action to be closed
M Joyes	**QS20/85.7** QSE to receive anonymised RIDDOR reports	July	Example provided to the Chair and subsequent reports discussed on 16th June 2020. Awaiting further update on recent investigations from Peter Bohan	
G Harris A Miskell	**QS20/85.8** Further to response to action QS20/27.5, difficulties in cleaning Ward 19 YGC to be discussed at QSG and further confirmation required that the ward is fit for purpose in respect of cleaning difficulties.	July	Ward 19 is currently a Care of the Elderly ward. Due to the environment we are unable to carry out a HPV clean. Although we are able to use UV and carry out an amber clean. HPV is the gold standard to destroy any bioburden in the environment. There are shorter distances between the beds and limited (to be clarified) air exchange. The cohort of patients and the interactions, use of medical devices and aids means the environment becomes quite cluttered at times. There are no ensuite facilities and one of the side rooms is accessed via a bay. Ward 19 has experienced the most outbreaks of infection and more recently Covid 19 and norovirus. The ward would be more suited to a more mobile/fit for discharge cohort of patients.	

M Joyes	**QS20/86.2** Amend SUI report to remove reference to the GP surgery and republish this report to ensure anonymity.	May	Report amended 05.05.2020 following the meeting	Action to be closed
J Newman	**QS20/86.3** Clarify further details of changes made to BPAS service and review in line with the incident.	July	Information circulated internally.	Action to be closed
M Joyes	**QS20/86.6** Committee to receive a report on incident reporting including terms of reference for incident reporting including process of analysis and actions to be taken	July	Included within Item QS20/110	Action to be closed
M Joyes	**QS20/86.8** Further update to be provided on the never event sent for specialist review to determine if a full independent review is undertaken or not.	July	Included within Item QS20/110	Action to be closed
L Reid G Harris D Fearnley	**QS20/87.7** Circulate a series of questions in response to vascular update to Independent Members, for the Board to respond to and meet further with GH and DF to review what can be done about specific areas of concerns and to agree the best way forward from a governance perspective	July	Questions were circulated and an initial response was provided. Further clarification has been subsequently sought.	
J Newman	**QS20/88.3** confirm investment position to enable year 1 of Stroke implementation plan	July	Requirement for this investment was included in the budget set paper which went to the Board for 2020/21	Action to be closed
L Reid J Newman	**QS20/89.5** Discuss specific requirements for analysis and risk assessment within ophthalmology with JN outside of the meeting.	July		
G Harris D Fearnley	**QS20/93.5** present the clinical element of pathways to QSE so the committee is sighted on the level of risk associated including	July	Risks associated with clinical pathways are being developed to help safely prioritise the implementation. A report on the clinical pathways future developments will be prepared to align with	

	essential services and to ensure governance processes.		the planning cycles. Progress will be reported at the next QSE meeting.	
L Reid	**QS20/94.1** the Chair to circulate concerns in relation to the Corporate Risk Register to members outside the meeting.	July	Information shared with Justine Parry and QSE Members	Action to be closed
L Reid J Hughes L Meadows C Carlisle G Harris	**QS20/95.6** Ward Accreditation – consider how best to provide the appropriate assurance to QSE and Board that learning is shared.	July	Work in progress, to be considered in conjunction with the YGC review	
M Joyes	**QS20/96.1** Amend bullet points within section 2 of the H&S Report to be more explicit if death is attributable to COVID. Also amend final sentence relating to staff testing positive.	July	The procedure has been updated as requested and further fully updated in mid-June 2020in light of new national guidance.	Action to be closed
M Joyes	**QS20/96.2** Provide feedback to national team re H&S report.	July	The Health Board contributed to the national working group developing the all-Wales toolkit, which has now been issued to all Health Boards and Trusts	Action to be closed
G Harris	**QS20/97.2** Amend narrative to make it clearer within the Annual Report that processes in place to ascertain patient feedback and collate information and data but focus is required to use this more effectively to provide assurance that work is progressing.	July	This has been actioned	Action to be closed
C Brennan	**QS20/97.6** Add sentence to attendance section 4 of the report to affirm the technical difficulties prohibiting Cllr Cheryl Carlisle's attendance on 17th March	July	This has been actioned	Action to be closed
L Reid	**QS20/97.7** Provide additional narrative for page 13 of the Committee Annual Report relating to focus for the year ahead which was	July	This has been actioned	Action to be closed

	written prior to the pandemic. The cycle of business will also be revisited.			

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Infection Prevention (IP) Report June 2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris - Deputy Chief Executive / Executive Director of Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Amanda Miskell – Assistant Director of Nursing (ADN) – Infection Prevention
Craffu blaenorol: Prior Scrutiny:	Gill Harris - Deputy Chief Executive / Executive Director of Nursing and Midwifery
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the Infection Prevention report.

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

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

Sefyllfa / Situation:

The IP exception report will update the Health Board (HB) on the position of IP performance and any associated risks relating to IP.

For this report a summary on:

1. COVID 19 clusters and lessons learnt
2. Key IP issues
3. 2020/21 trajectories for performance
4. Reconvening IP governance structure and Internal Decontamination audit

Cefndir / Background:

Infection Prevention performance and reporting is a mandated requirement for the Health Board. This report provides a position statement of the Health Boards Infection Prevention status in relation to agreed trajectories, quality improvements, harms and exception reporting.

Asesiad / Assessment & Analysis:

Introduction

BCU have a zero tolerance to any avoidable infection (I) that is either Community Onset (CO), Hospital Onset (HO) or Health Care Associated (HCAI). An 'avoidable' infection can be defined as 'a breach in infection prevention practice which may have contributed to the infection occurring and in which learning has been identified'. The Infection Prevention work programme is multifaceted with engagement and support required from the Clinical Multi-Disciplinary Team, Estates and Facilities, and Pharmacy in relation to antimicrobial stewardship and resistance.

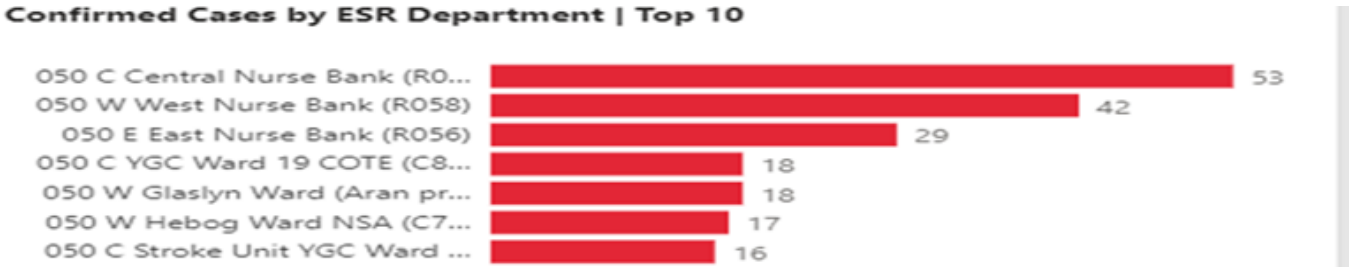
Covid 19 Clusters and lessons learnt

The previous two months have seen a number of clusters related to Covid 19 in some of our inpatient wards. Areas affected were Ruthin (2) and Holywell. In acute sites: Ward 19 (2) and Ward 14 at YGC. Mason Ward at YWM and Hebog at YG. All had immediate cluster review meetings convened which continued through to conclusion of the clusters. All Area and Site HMT, Facilities, Estates, IPC, H&S were included and where necessary a Microbiologist. More recently, the newly appointed PHW Epidemiologist has also attended. There have been consistent themes in all of the lessons learnt, which include, not exclusively:

1. Non-symptomatic positive patients identified on cluster IPC management or pre discharge screening.
2. Track, Trace and Protect which commenced on 1st June has also increased the number of cases identified as Non symptomatic carriers
3. Lapses in social distancing compliance, particularly around break times, handover and commute to and from work
4. Movement of staff, both within and outside of the HB, e.g. redeployment due to clinical need , additional roles, Bank and Agency staff
5. Patient to Patient transmission due to patient to patient engagement e.g. smoking, interaction in and around the hospital despite communications
6. Bed spacing compliance
7. Lack of appropriate ventilation and air exchange of which is a conduit for aerosol spread
8. Bed space congestion where equipment is vital for patient care
9. Multiple use of equipment and multiple care interactions by a wide MDT
10. Utilisation of level 2 PPE when not required as per guidance which provides false assurance
11. Application of basic IP guidance

To address the lessons learnt the focus for the Infection Prevention alongside the MDT is to continue to articulate the learning and reinforce National Guidance and the fundamentals of basic IP practice.

As we have seen a greater staff than patient COVID prevalence, with the majority of staff testing positive being Bank staff, this reinforces the need for adherence to IP practice and Social distancing.



Key IP Issues

Ward 19 – the HMT at YGC continue to work with Area colleagues regards patient pathways to facilitate the closure of ward 19 in its current location and support this patient group on ward 2. This was aimed for 29th June 2020, however due to the increased prevalence of COVID-19 in the Central area this is currently delayed. As an immediate action bed capacity has been reduced to allow for greater social distancing given the Patient cohort.

Invasive Devices - Work related to the timely removal of unnecessary invasive devices continues in the hospital settings. For community invasive devices, in particular Urinary Catheters the audit planned for Spring 2020 has had to be postponed. This coincides with the consideration of increasing access to Trial Without Catheter (TWOC) clinics and an increase in those awaiting Trans Urethral Resection of Prostate (TURP). As we look to reintroduce essential services and routine activity this will be reinstated. There is significant evidence that:

- Links a large proportion of infections to community onset as opposed to hospital acquisition
- Although a device is insitu, there is an absence of health care intervention in an associated preceding timeframe.
- A proportion of blood stream infections do not have a medical device and or health care intervention associated.

Trajectories

As yet no Improvement Goals for Health Care Acquired Infections (HCAIs) have been set by Welsh Government for this financial year, however HBs and Trusts, “are encouraged to continue to strive to reduce healthcare associated infections in line with the overall requirements of the UK 5 year AMR strategy and action plan”. For BCU this will be a continuation of the trajectories for 2019/20 taking into consideration the 12% reduction applied to Clostridium Difficile Infection (CDI) for 2019/20.

The numbers of infections in terms of rates/1,000 admissions to date have increased across Wales. This is likely, in most cases to be due to a reduction in elective admissions in recent months. That said, we continue to monitor these numbers closely, and will continue to respond and report any potential clusters and or significant increases and trends. Considerations of remote prescribing due to COVID 19, with the addition of gaps in East and Centre of Antimicrobial Pharmacists should be noted.

Ribotying variations would suggest an environmental bioburden of Clostridium difficile, particularly in the acute sites for West and Central, with admission areas particularly affected. It is not as apparent in the East, however an increase in the number of cases during April was likely due to an earlier interruption of the bay-to-bay deep cleaning programme using Hydrogen Peroxide Vaporisation (HPV). Although there is a commitment, from site, HMT’s regards the deep clean programme, this has been impacted by capacity and access to regular decant accommodation. The decant programme has been added to the IPSG work plan and will be monitored via that group regards progress. Alongside this as previously escalated has been the challenges regards recruitment into our cleaning teams in a timely manner, which has since seen the overall numbers reduce with current vacancies as follows:

YGC – 10.8 WTE = 405hrs per week

WMH – 8.4 WTE = 315hrs per week

YG – 0.09 WTE = 33.79hrs per week

Monthly variation is anticipated; trends provide more accuracy with respect to the overall direction of infection rates and associated prevalence. CDI infections are slightly higher than the same period last year (April – May 2020 but have decreased from previous month, April 2020.

Reported MRSA infection numbers reported by PHW (2 in May) were inaccurate, due to a laboratory error whereby an MSSA Blood Stream Infection (BSI) infection, was recorded as an MRSA BSI. This error has been reported via Datix and we have been assured this will be removed for next month's reporting by PHW.

The second reported MRSA infection was not as a result HCAI; this was acquired via IV drug use, self-induced within the community. We still have this reported as a BCU Infection. There is no process in Wales to have these removed even with a robust scrutiny in place that it was not a HCAI and that it was not within our control to avoid this infection.

Compared to the same period last year, MSSA infections and all the other gram negative infections are lower, with the exception of Pseudomonas, by 1. 8 infections were reported at the end of May, 50% were community onset with positive blood cultures on admission.

PPE

The PPE steering group continues to meet twice weekly, with extraordinary meetings as required. Challenges continue with regards National Stock supply, which has resulted in the ongoing response to additional Fit Testing for staff to ensure access to the appropriate PPE. Quality of some of the PPE received has been escalated to the National group. Communications continue, with the focus being on consistent messaging against the backdrop of National change and statements from National Professional bodies. PPE/IP Champions support the work of the IP team about support and messaging for staff across the HB. The number of queries coming through to the PPE SRO inbox has significantly reduced.

During these unprecedented times, it has further magnified the limitations of the HBs current IP resource. There is a review underway to determine requirements moving forward to meet both the operational and strategic requirements of the HB.

Governance for IP

The formal meeting arrangements for IP have resumed with the first IPSG taking place early June 2020. This has been followed by the Local IPGs (LIPGs) and the Decontamination Group, early July 2020, with issues of significance escalated to IPSG and QSG as required.

The internal audit for Decontamination recommended with the LIPGs having a key role to play in escalating decontamination issues to the IPSG. IPSG terms of reference have been reviewed and are inclusive of this change. Agreement has been gained for a further post to sit in IP and support the Decontamination Advisor across the Health Board with interviews taking place mid-July.

Financial Implications

1. Staff absence for self-isolating, shielding and symptom management.
2. Fit Testing equipment and more half mask respirators for Fit Test failures.
3. Doors for Ward 14 on Bays
4. Movement of Ward 19
5. Additional decontamination resource

Risk Analysis
Infection prevention is currently on the Risk Register and a PPE risk register has also been developed via the PPE steering Group chaired by The Executive Director of Nursing.

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

Reporting to HSE via RIDDOR for any dangerous occurrences relating to staff infections.

Bed Spacing and Air exchange monitoring.

Impact Assessment
No impact applicable to this report.

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Serious Incident Report – April and May 2020
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance & Assistant Director of Patient Safety and Experience and Dr Kath Clarke, Head of Patient Safety
Craffu blaenorol: Prior Scrutiny:	Review by the responsible director and executive director
Atodiadau Appendices:	Serious Incident Report – April and May 2020

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to

- note the report.
- note the changes of Welsh Government serious incidents reporting requirements
- note the implementation of the Make it Safe process.

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

Sefyllfa / Situation:

This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months although 14 months of trend data is included to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the quarterly Patient Safety Report.

Cefndir / Background:

A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in: the unexpected or avoidable death of one or more patients, staff, visitors or members of the public, another serious occurrence from a specified list or one of the specified Never Events.

Asesiad / Assessment & Analysis

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

Serious Incident Report
April and May 2020

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

2. INTRODUCTION

- A serious incident is defined as an incident (not exclusively a patient safety incident) that occurred in relation to NHS funded services and care resulting in:

    - the unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
    - permanent harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy (this includes incidents graded under the NPSA definition of severe harm);
    - a scenario that prevents or threatens to prevent an organisation's ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment;
    - a person suffering from abuse;
    - adverse media coverage or public concern for the organisation or the wider NHS;
    - the core set of 'Never Events' as updated on an annual basis.

- With effect from Monday 23rd March 2020, as part of interim COVID-19 contingency measures, only the following incidents need formally reporting to the Welsh Government under the serious incident framework (following a temporary revision to PTR requirements advised by the Deputy Chief Medical Officer):

    - never events
    - maternal deaths
    - neonatal deaths
    - in-patient suicides
    - mental health homicides
    - unexpected deaths where the death is related to healthcare service delivery/failures
    - Human Tissue Authority incidents
    - IR(ME)R reportable radiation incidents
    - other incidents of severe avoidable harm caused by healthcare service delivery/failures

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

- Since April 2010, all serious incident notifications have been reported electronically to the Improving Patient Safety Team Mailbox at the Welsh Government. This should be done with 24 hours of the incident. The Welsh Government respond within 24 hours and set-out a grade of the incident:

    - Grade 0 - Concerns currently and commonly referred to as a 'no surprise' and/or where it is initially unclear whether a serious incident has occurred will be graded 0. Unless further information is received, the Welsh Government will automatically close the incident after 3 days and no further correspondence with the Welsh Government is required.
    - Grade 1 - It is expected that a comprehensive investigation will need to be completed by the Health Board organisation within 2 calendar months. In order to close this incident the Welsh Government require confirmation that an appropriate investigation has been

undertaken, has been reported to an appropriate committee, an action plan developed and where relevant has identified any actions for wider learning and dissemination. A closure/update report form is completed and submitted for this purpose.

- Grade 2 - This will follow a similar process to the above. A comprehensive investigation is required, and in some cases the incident may be referred for independent external review by Health Inspectorate Wales (HIW) or another regulatory body. Grade 2 incidents will be subject to ongoing monitoring by Welsh Government and final agreement through its Patient Safety Committee that the incident has been investigated appropriately and thoroughly before closure. Examples of such incidents could include mental health homicides, maternal deaths, clusters of similar incidents and never events.

- This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last month and a half (since the Committee's last meeting) although 14 months of trend data is included to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the Patient Safety Report.

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

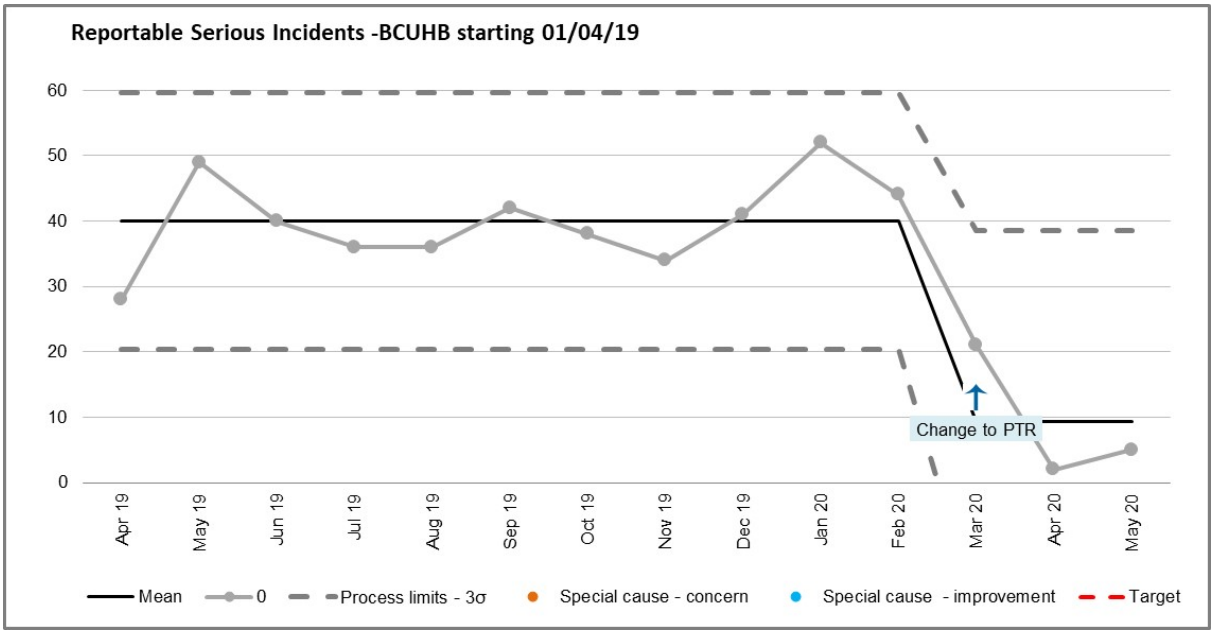
    - A data point falling outside a process limit (upper or lower) indicates something unexpected has happened as 99% of data should fall within the process limits – the process limits are indicted by dotted grey lines.
    - Two out of three data points falling near a process limit (upper or lower) represents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

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

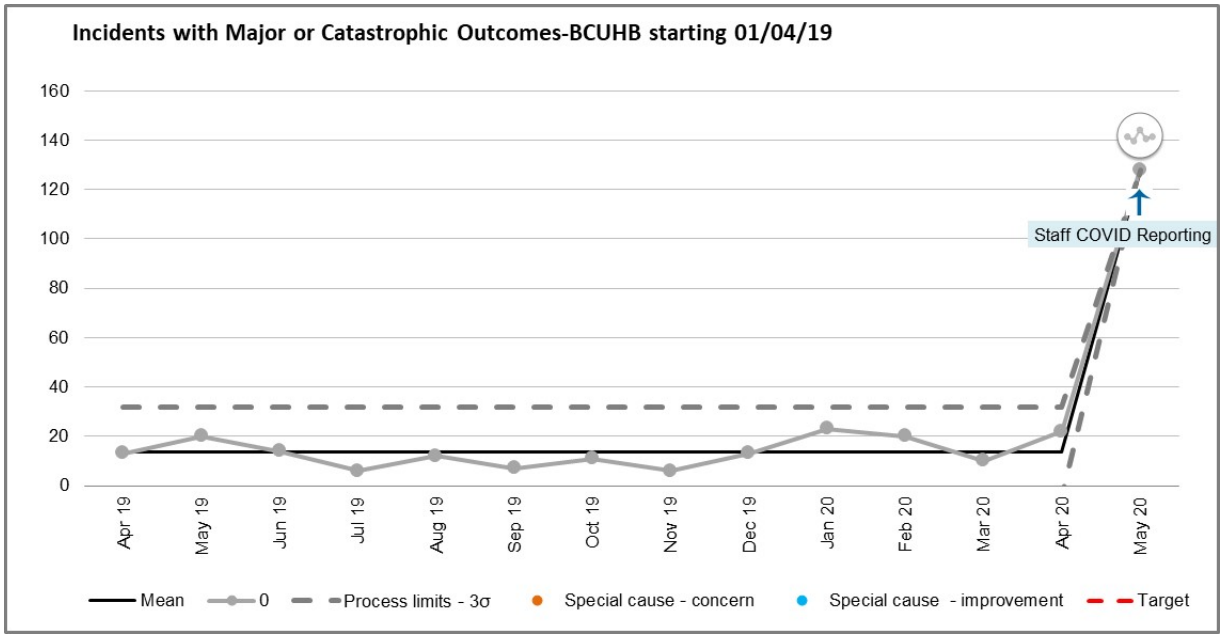
Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling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

3. OVERALL SERIOUS INCIDENTS

- During the time period under review, 7 serious incidents were reported compared to 77 in the comparable prior period (please note the change in PTR reporting criteria outlined above).



- The following chart shows incidents with Major or Catastrophic outcomes. Although it appears to show a significant increase in May 2020, please note this primarily relates to staff who have tested positive for COVID and have been initially logged as Major outcomes. Most of these will be downgraded as the incidents are investigated and reviewed. This issue accounts for 88 incidents in May 2020. The remainder of the increase relates to COVID outbreaks on the wards. When this data is excluded, there does not appear to be an increase in incidents with Major or Catastrophic outcomes



- The common categories of reported serious incident are as follows (this includes every category where four or more serious incidents have been recorded) – at the time of writing investigations are underway:

- Outbreaks. During the two months, 8 outbreaks were reported on Datix relating to COVID19.
- Patient falls (which included the following categories: fall down steps; fall from a height, bed or chair; fall on level ground; tripped over an object). 11 incidents fitted into this category during the reporting period. Patients died in 4 cases, of which 2 have been identified as natural cause deaths and 2 have been referred to the Coroner, HSE and serious incident investigations are underway.

- At the time of writing (10.06.2020), 59 serious incidents remain open with Welsh Government (down from 107) of which 46 are overdue. Of these, the predominance of overdue incidents relate to Ysbyty Glan Clwyd (5), Central Area (10), Mental Health, and Learning Disability (9). All divisions have seen and continue to see a reduction in overdue incidents. A small number of incidents are overdue by twelve months (3) and these mostly relate to matters subject to police investigation. A number (9) are overdue by 6-12 months and a larger number (10) are overdue by 3-6 months. There has been significant reduction over the last 12 months and divisional governance teams are taking focused action to reduce this further.

- The Patient Safety and Experience Department were planning a comprehensive review of the incident process and this will be conducted in co-production with divisions and other stakeholders. This work was due to commence in March 2020 but due to COVID 19 pandemic has been put on hold for the foreseeable future. A revised plan has now been developed and the intention is to engage and develop a new process for launch on 01 January 2021. This will allow time for engagement (July/August), development (September), approval (October), and implementation including training and system changes (November/December).

4. SPECIFIC SERIOUS INCIDENTS

- The following serious incidents reported during the reporting period are being specifically highlighted for the attention of the Committee:

    - WMH – Patient passed away following an unwitnessed fall. Referred to Coroner, and RIDDOR reported. Discussions with Coroner ongoing. Full Serious Incident Review commissioned due in mid-August in line with PTR deadlines.
    - YGC - Patient passed away following an unwitnessed fall. Referred to Coroner but no inquest opened. RIDDOR reported. Post mortem conclusion was the patient died of natural causes and the fall did not contribute to the patient's death. Full Serious Incident Review commissioned due in mid-August in line with PTR deadlines.
    - WMH – Death of a staff member from COVID-19. A health and safety investigation has been completed and the Coroner and HSE have ongoing enquiries.
    - Vascular Network/YGC – Death of a patient possibly contributed to by failure to review medication. Referred to Coroner but no inquest opened. Full Serious Incident Review commissioned due in mid-August in line with PTR deadlines.
    - WMH – Missing controlled drugs. A police investigation is underway.
    - YGC - A cluster outbreak of Covid-19 infection occurred in the haemodialysis unit affecting 21 patients and 15 members of staff. Outbreak review completed.
    - YGC – A cluster outbreak of of Covid-19 infection occurred on ward 14 affecting 14 members of staff
    - Heddfan Unit – A patient died of COVID19 who should have been subject to shielding and a shielding plan appears not to have been in place. Full Serious Incident Review commissioned due in mid-August in line with PTR deadlines.

- Chirk Community Hospital - Six patients affected with COVID-19; out of the six patients, two died, with the rest being symptomatic/testing positive with COVID-19. Outbreak review completed.
- Ysbyty Cefni - Death of four patients who tested positive for COVID-19. Outbreak review completed.
- Community - Paediatric death (7-week-old baby). PRUDIC investigation underway, initial review highlighted issues with the resuscitation equipment at GP surgery. Support has been provided by the Resuscitation Team.

5. NEVER EVENTS

- During the reporting period, two Never Events were reported:

  - YGC – a patient having a hemiarthroplasty had a block applied to the wrong side. The error was noted prior to the spinal block. No adverse outcome for the patient. An immediate Make it Safe rapid review was completed and issues were identified regarding distractions in theatre pre-surgery. An investigation is underway.
  - WMH - Surgical chest drain insertion for empyema inserted on the wrong side. No adverse outcome for the patient. An immediate Make it Safe rapid review was completed and issues were identified regarding the urgency of the care provided in Emergency Department and the absence of LocSSIP procedures. An investigation is underway.

- Since September 2019, the Health Board has reported six Never Events. Over the last 2 years the Health Board reported 16 Never Events, therefore the number of recent incidents is noticeable. The serious incident investigations are ongoing but at this stage, there does not appear to be a consistent underlying theme or recurring issue. Once all individual investigations are completed, the Patient Safety and Experience Department will conduct a thematic review to provide assurance around this.

- During the reporting period no Never Events were closed.

4.4 The Committee will be aware of a Never Event regarding urology at Ysbyty Glan Clwyd. The investigation for this was due for completion in mid-March 2020. The report was finalised in late April and has now been sent for independent review. Due to COVID-19, this process will take time to complete. The site have requested an opportunity to review the initial report and this is underway and a strengthened report is expected.

6. LEARNING FROM SI REVIEWS

5.1 The current serious incident process has been amended in response to Welsh Government changes to PTR and the current COVID 19 pandemic. The rapid review has been replaced with a “Make it Safe” process. A “Make it Safe Review” must be completed by the service within 72 hours for all severe and catastrophic incidents and submitted to the Corporate Patient Safety and Experience Department who will make a decision on whether the incident can be closed or whether a full serious incident review is needed. The decision will be communicated to the service within 24 hours. If the incident can be closed the Corporate Patient Safety and Experience Department will complete the Welsh Government closure form.

5.2 The immediate learning from the rapid reviews and actions is owned by the site/division, who will progress any immediate actions. A summary of the key learning from completed rapid reviews is detailed below (note, Never Events is covered in the above section):

- Following an incident in the Vascular Network/YGC (mentioned above), it was identified that pharmacy and nursing teams need to develop an improved Heparin chart, which subsequently needs to be shared across the Health Board.
- Following an incident at WMH, the important of proactively ensuring family contact was made and maintained was identified.
- A number of outbreak reviews all identified the importance of good infection control practice, clear guidance for staff and social distancing in the workplace for patients and staff.

5.3 Due to the low numbers of serious incidents occurring in the period under review (7), no new themes or trends have been identified to those previously reported. 69 closure forms were submitted to Welsh Government. Currently, learning and actions are held locally within sites/divisions which prevents overall analysis other than manually reviewing each individual closure form. Due to resource constraint arising from COVID, this manual review has not taken place as yet for these specific forms. As part of the incident process review mentioned above, learning and actions will move towards being recorded on a single, corporate system (Datix) to enable cross-site/division learning, and corporate triangulation. This approach will also provide assurance as evidence will be required and uploaded to close evidence.

5.4 A number of recurring issues have been identified in relation to surgical incidents and Never Events including the issues with completion of the WHO Checklist and LocSSIPS, both of which are underpinned by human factors – work is planned to explore this further between the nursing and medial directorates.

7. CONCLUSION AND RECOMMENDATIONS

- This report provides the Quality, Safety and Experience Committee with information and analysis on serious incidents and Never Events occurring in the last two months although 14 months of overall trend data is included (section 2.1 and 2.2) to allow for period on period comparison in the last year. Longer-term thematic analysis is included in the quarterly Patient Safety Report.

- The QSE Committee is asked to note the report.

- The QSE Committee is also asked to note the changes of Welsh Government serious incidents reporting requirements

- The QSE Committee is also asked to note the implementation of the Make it Safe process.

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Putting Things Right (PTR) Annual Report 2019-2020**
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Erika Dennis Business Manager, Corporate Nursing Anne Hall, Head of Quality and Assurance
Craffu blaenorol: Prior Scrutiny:	Prior discussion has taken place at the monthly Patient Safety and Experience Department Management Team (DMT) Meetings in April and May 2020. In addition, the report was submitted to QSG 12 June 2020 is scheduled for the Listening & Learning from Experience meeting in June
Atodiadau Appendices:	Appendices A and B, noted in "Recommendation".

Argymhelliad / Recommendation:

The Committee is asked to approve the PTR 2019/20 annual report which is currently being translated.

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

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

Sefyllfa / Situation:

Purpose

The PTR Annual Report is aimed at providing **assurance** and **evidence** to the public, Welsh Government, regulators and other stakeholders that the Health Board is dealing and learning from concerns in accordance with the Regulations and that concerns are being *'investigated once and investigated well'*.

As such, the purpose of this paper is to provide the Committee with assurance that the report has been prepared in line with regulation and to request approval in order that the report can be published.

Progress

The PTR Annual Report is published by the Health Board and other responsible bodies annually. This year there has been a delay with the progression of the report due to Covid-19. Despite this, work on

the report was progressed at the earliest opportunity and a project plan completed which incorporated the contents of the report, milestones required for completion and a cycle of business. The project plan was agreed at the Patient Safety and Experience Department Management Team (DMT) meeting on 12 May 2020.

In addition, the team completed a benchmarking exercise, which provided insight into how other responsible bodies completed their PTR Annual Reports last year. Subsequently, the team decided to follow a similar format to the Public Health Wales PTR Annual Report 2018/2019, as the report was concise yet comprehensive. It also ensured consistency in terms of how data is presented.

Contents

The Patient Safety and Experience Department are pleased to provide the Committee the final version of the report. The report provides a synopsis of themes and trends emerging from concerns collectively and a high-level summary of lessons learnt. It is not intended to provide detail of learning in individual cases as this is shared on a regular basis through the Divisional & Corporate Quality and Safety Groups and the Quality, Safety & Experience (QSE) Committee.

The committee are asked to note the following key information when reviewing the report;

- **A Putting Things Right Overview of 2019/2020**, is located on page 3.
- **Looking Back: Learning and Achievements over 2019/2020**, is located on page 4 and provides an insight into the challenges which the Health Board has faced and improvements made.
- **Putting Things Right** detail of all concerns collectively, including themes and learning, is located on pages 5 to 21.
- **HASCAS and Ockenden Improvement Work**; an update can be found on page 11. This is a key element to PTR, following the independent investigation in relation to the complaints, concerns and professional regulation and employment issues arising from the significant failings in care on Tawel Fan ward.
- **Patient Experience** has been incorporated into the report this year as it is key to the Health Board understanding what receiving care feels like for the patient, their family and carers. It is also a key element of quality, alongside providing safe and clinically effective care. In addition, as part of the departmental delivery plan and review of our processes, complaints now sits with Patient Experience.
- **Covid-19,** this section is located on pages 27 and 28. As a consequence of the Covid-19 pandemic, the Patient Experience and Patient Safety department have embraced new ways of working. This section provides an overview.
- **Looking Forward: Aims and Priorities for 2020/2021**; this section provides an overview of how the department will will strengthen the outcomes of our work to aid future improvement work and engagement. It also confirms a comprehensive review of the concerns process collectively.

Annual Quality Statement

For Local Health Boards and NHS Trusts, the report should be published in support of the organisation's Annual Quality Statement (AQS). The AQS is scheduled for publication on 30 September 2020. The AQS will provide a clear link to the Health Board's PTR Annual Report 2019/2020 in terms of contents and signposting, ensuring that they are both aligned.

Future planning of the PTR Annual report

Following publication of the PTR Annual Report, the Patient Safety and Patient Experience Department will develop a template for the 2020/21 report based on feedback from the Listening and Learning Group, QSG & QSE. We will also include the PTR Annual Report in the departmental cycle of business over the next year. This will ensure that there is a focus on the report throughout the year and will allow sufficient time for the planning of contents, implementation and future engagement.

Cefndir / Background:

The report is required by 2011 No.704 (W.108) National Health Service, Wales The National Health Service (Concerns, Complaints and Redress arrangements) (Wales) Regulations 2011 51 (1) at **Appendix A**. As such, the report for 2019/20 has been prepared in line with the Regulations and is intended to provide an overview in terms of how the Health Board has managed Concerns for the reporting period.

Regulation 51 provides that each Responsible Body must prepare an annual report for each year. The report must contain, as a minimum:

- Number of concerns received (including, in the case of Welsh NHS bodies, concerns reported under Part 7 of the Regulations related to cross border services);
- The number of concerns deemed well founded; and
- Number of concerns referred to the Public Services Ombudsman for Wales.

13.2 In accordance with regulation 51(1)(d) the annual report should also summarise:

- The nature and substance of concerns received;
- Any matters of general importance arising out of these concerns or the way that they were handled including areas of concern within particular departments, staff groups, treatments or services provided, that is reporting on trends; and
- Actions taken to improve services as a result of a concern/s being notified

At all times the organisation must ensure that the annual report does not identify individuals or any related sensitive information

Asesiad / Assessment & Anaysis

Strategy Implication

The Health Board must manage and learning from concerns in accordance with the Regulations and ensure that concerns are being *'investigated once and investigated well'*.

The report should be published in support of the organisation's Annual Quality Statement.

Financial Implications

Failure to provide safe care, can result in a complaint, claim and redress compensation of which there can be significant financial implications.

Risk Analysis

There is a risk of harm to patients and staff if the standards of care and treatment provided to patients, fall below what is required. If staff are unable to provide suitable care, there is a risk of harm to the patient. There is also a reputational risk, particularly in terms of the press following any negative reports and immediate concerns.

Financial risk is associated with costs of any claims.

Legal and Compliance

There is a risk of non-compliance with regulations the standards of care and treatment provided to patients, fall below what is required.

Impact Assessment

This report is administrative, there are no associated impacts or specific assessments required.

WELSH STATUTORY INSTRUMENTS

2011 No. 704

The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011

PART 9

MONITORING THE PROCESS

Annual report

51.—(1) Each responsible body must prepare an annual report for each year which must—

(a) specify the number of concerns which were notified to the responsible body, including, in the case of Welsh NHS bodies, any concerns that were notified to it in accordance with the provisions of Part 7;

(b) specify the number of concerns which the responsible body determined to be well-founded;

(c) specify the number of concerns that the responsible body has been advised have been notified to the Public Services Ombudsman for Wales;

(d) summarise—

(i) the subject matter of concerns which were notified to the responsible body;

(ii) any matters of general importance arising out of those concerns, or the way in which they were handled;

(iii) any matters where action has been taken or is to be taken to improve services as a consequence of those concerns.

(2) This paragraph applies to a responsible body which is—

(a) a Welsh NHS body other than a Local Health Board; or

(b) a primary care provider or an independent provider,

and which in any year provides, or agrees to provide, services under arrangements with a Local Health Board.

(3) A responsible body to which paragraph (2) applies must send a copy of its annual report to the Local Health Board which arranged for the provision of the services by the responsible body.

Putting Things Right Annual Report 2019-2020

Concerns (Complaints, Claims and Patient Safety Incidents) and Patient Experience

GIG CYMRU NHS WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

INTRODUCTION

Betsi Cadwaladr Health Board recognises that patient safety and experience, public engagement and involvement is a vital aspect of the Health Board's governance arrangements. The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (the Regulations) came into force on 1st April 2011, to enable Responsible Bodies to effectively handle concerns.

The aim of the regulation is to streamline the handling of concerns and under the '*Putting Things Right'* (PTR) arrangements, all NHS Wales organisations should aim to "investigate once, investigate well", ensuring that concerns are dealt with in the right way, the first time around. The term "Concern" relates to any complaint, claim or reported patient/service user safety incident about NHS treatment or service.

This means, that whenever concerns are raised about treatment and care, whether through a complaint, claim or patient safety incident, those involved can expect to receive a prompt acknowledgement and response, about how the matter will be taken forward, be dealt with openly and honestly and have an appropriate investigation undertaken into the concerns raised.

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

This annual report has been prepared in line with the PTR Regulations to provide an overview of the 2019/2020 position in terms of how the Health Board has managed concerns during this time. It provides an overview of themes and trends emerging from Concerns including some of the lessons learned.

In October 2019, we were very pleased to welcome our new Assistant Director of Patient Safety and Experience who has brought a wealth of experience to support our commitment to patient safety and experience.

PUTTING THINGS RIGHT OVERVIEW OF 2019/2020

Formal Complaints:

1866

Response times

Acknowledged 2 working days: 94%

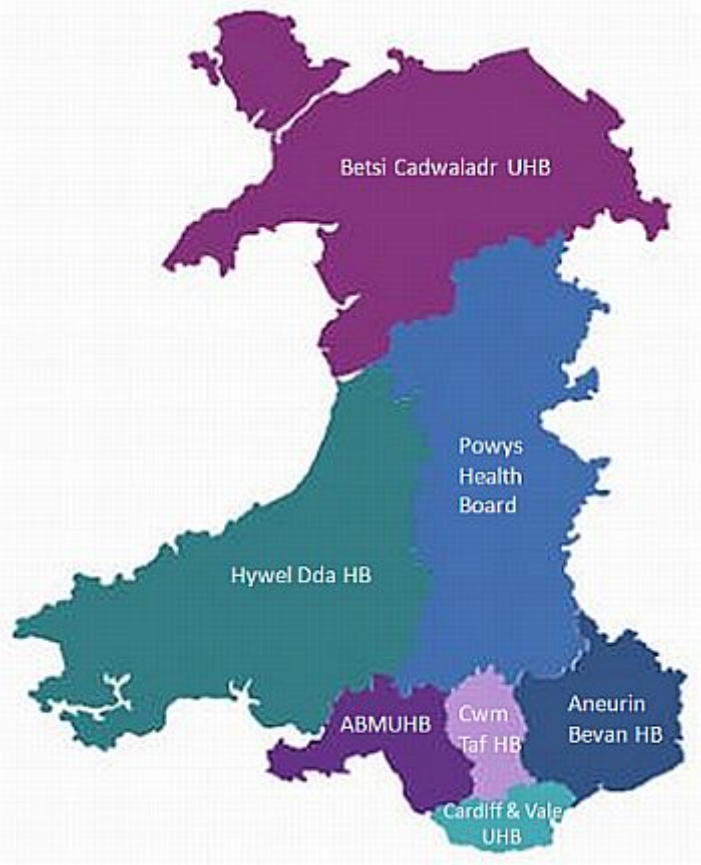
30 working days response: 47%

OTS Complaints (Informal):

3294

Compliments:

784



Redress Cases:

80

New Claims:

307

Incidents:

35628

Never Events:

6

LOOKING BACK: LEARNING & ACHIEVEMENTS

Learning and Achievements over 2019/20

The main challenge for the Health Board throughout the financial year has continued to be the managing of concerns in a timely way. To help us improve this, significant work continued in 2019/20 which includes the implementation of the Patient Advise and Liaison Service (PALS), on all three main hospital sites. This service provides support, advice and resolution to patients and awareness of the Service was raised amongst staff and members of the public across all our hospital sites.

At the end of 2019 a comprehensive review of PTR complaints procedure was commenced. This has resulted in an ongoing restructure of the Patient Safety and Experience Department that supports our commitment to meet the PTR regulations requirements.

A rapid review for all serious incidents was introduced that has improved immediate learning from complaints and incidents that sets in motion the investigation process in a timelier manner.

Feedback has been received during the year via 'Viewpoint' our real time feedback system that is used by staff and managers to support quality assurance, ward accreditation and service improvement. Comment cards and monthly patient questionnaires provide a variety of ways for patients (inpatient and outpatients), families and members of the public to feedback their experiences, whether positive or negative , that is used to continuously improve services.

A Learning from Events Redress process has been introduced to ensure that lessons learned from serious incidents and complaints are used to provide assurance and evidence of changes to clinical practice.

The Health Board approved its current Patient Experience Strategy in June 2019 and this can be accessed via our web site (the link can be found in our useful links section on page 30). The strategy is planned for a refresh in December 2020 to capture learning from the first year of implementation and to consider integration of wider issues such as carer engagement, involvement and support. This will be together with a refresh of the Patient Safety Strategy and Quality Strategy.

Complaints

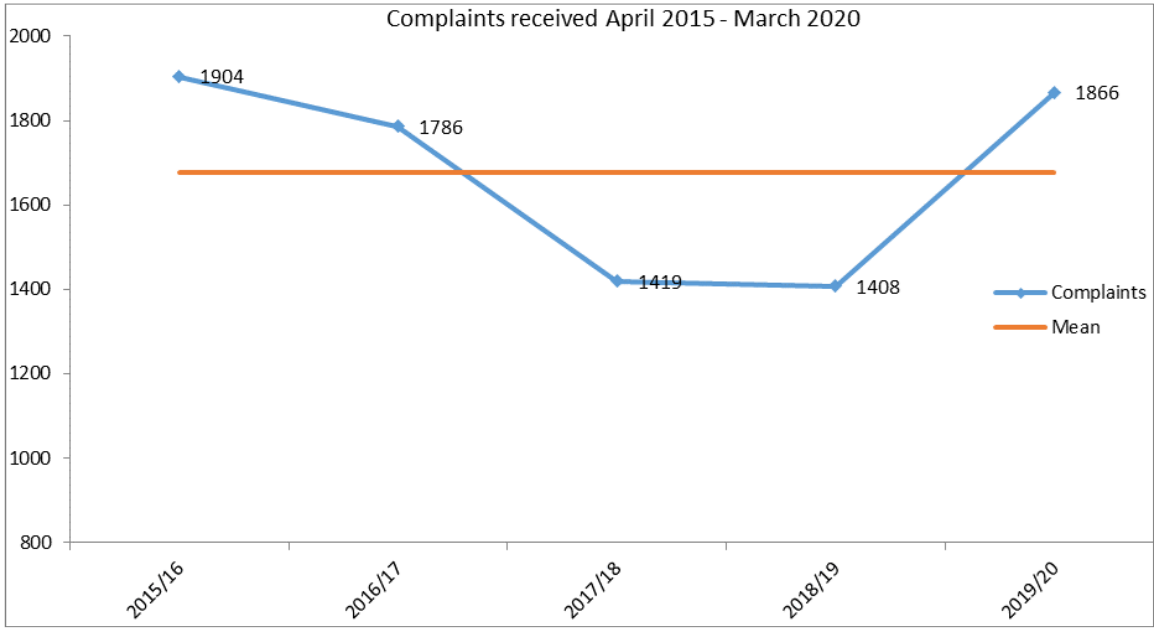
All complaints received by the Health Board are managed in accordance with NHS Concerns, Complaints and Redress Arrangement (Wales) Regulation 2011. The range of complaints received by the Health Board are diverse, complex, and sometimes overlap a number of services, therefore, to assist in the most appropriate investigation an individual raising a complaint may be invited to discuss this with a member of the Patient Experience Team. This not only allows a deeper understanding of the questions that complainants wants answering, it also enables the patient experience team, along with the wishes of the complainant, to undertake either a local resolution , or alternatively guide, monitor, and assure the complaint through the formal PTR procedure.

The Patient Safety and Experience Department is currently undertaking a comprehensive review of the complaints strategy and operational management of complaints. This has included Ysbyty Maelor, Ysbyty Glan Clwyd and Ysbyty Gwynedd and community services in an inclusive consultation, with teams; parallel to workshops being held with a range of partner agencies including amongst others Community Health Councils (CHC), and the Public Service Ombudsman for Wales (PSOW). Whilst this review has been temporarily suspended due to the COVID-19 outbreak, it now remains active with the consultation outcomes being utilised to underpin a new Complaints process, which is currently being compiled.

Complaints activity

The reporting period from 1st April 2019 to March 31st 2020 saw a rise in the number of complaints received, up from 1408 to 1866; this figure being above the average. However, this rise should be viewed as positive, as it reflects an increased willingness by service users to access the complaints team, and register their complaint in the most effective manner. Furthermore, this upward trend of reporting is also being mirrored by clinical staff, who following increased training from the Patient Experience Teams, increasingly signpost service users to the complaints team, or actively manage, and document on the spot (OTS) 'early resolution' complaints . This adherence of policy has the benefit of ensuring that service users concerns are actively managed, monitored, and guided throughout.

The chart illustrates the rise in complaints received over a five year period. It is of note that whilst the last figure remains above the annual average, this is in contrast to 2017/2018 and 2018/2019 figures



On the Spot (OTS) 'Early Resolution' Complaints

On the spot 'early resolution' complaints have risen in the period for 1st March 2019 – 31st March 2020, from 2985 to 3294. This may, as previously mentioned be attributable to more accurate recording of OTSs in clinical environments, but this theory is not conclusive without further evidence. What is of note are the number of OTSs being upgraded to formal, 12.8%. This may be resultant from the complainant remaining dissatisfied, or the PTR timescales not being met (OTS complaints need to be resolved within 48 hours or upgraded to a formal complaint). This again will be a focus in the new complaints procedure, as not meeting timescales resulting in formal responses, is neither beneficial to the complainant nor the service.

Formal complaints performance

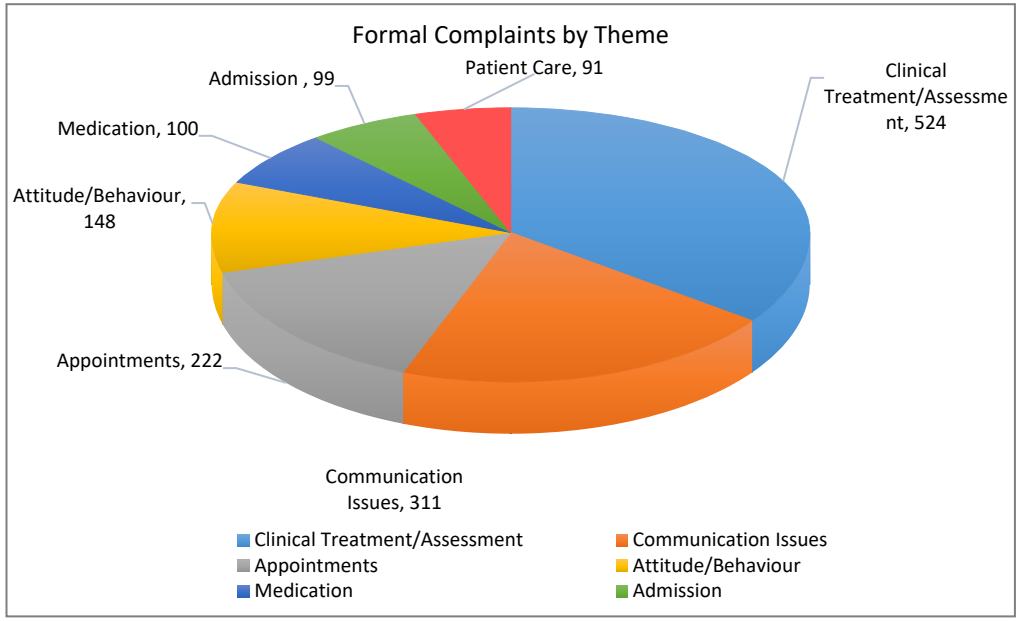
Formal Complaints	2015/16	2016/17	2017/18	2018/19	2019/20
Total Number of Formal Complaints	1904	1786	1419	1408	1866
No of complaints acknowledged within 2 working days	1453 (76%)	1544 (86%)	1298 (92%)	1307 (93%)	1749 (94%)
No of complaints responded to within 30 working days of receipt	449 (24%)	552 (31%)	487 (34%)	482 (34%)	885 (47%)
No of complaints responded to within a period exceeding 30 working days but within 6 months	1079 (57%)	1064 (60%)	846 (60%)	826 (59%)	876 (47%)

The comparative performance of the PTR Key Performance Indicators is outlined in the chart above. Of note is the slight increase of concerns being acknowledged within two working days up to 94%, set against a target of 95%. There is also a significant increase in the number of complaints being responded to within thirty days of receipt, up from 34% to 47%. It is acknowledged that whilst this is below target, which is set at 75%, it is an upward trend which will continue along with the greater involvement from those services involved. The final performance indicator outlines the number of concerns responded to within a period exceeding thirty days, but within six months. This has fallen from 59%

47%, which whilst disappointing, may reflect the complexity of the complaint, and the wide range of professionals involved in the complaint. This delay has been acknowledged by the Patient Experience Team, and will be scrutinised and acted upon during the overhaul of the Complaints process.

Complaints Categories

The chart above indicates the range of complaints received over the period March 31st 2019 – 1st April 2020. This data is useful in that it allows training to target those identified areas, an example being customer care. However, whilst the range of complaints within those categories are too diverse to be outlined within this report, themes and trends within areas are recognised and escalated in real time to the Heads of Services. There is also a requirement that learning is demonstrated in response to each individual complaint. The maintenance and audit of improvement will also be an area which the new complaints process will focus on.



Public Service Ombudsman for Wales

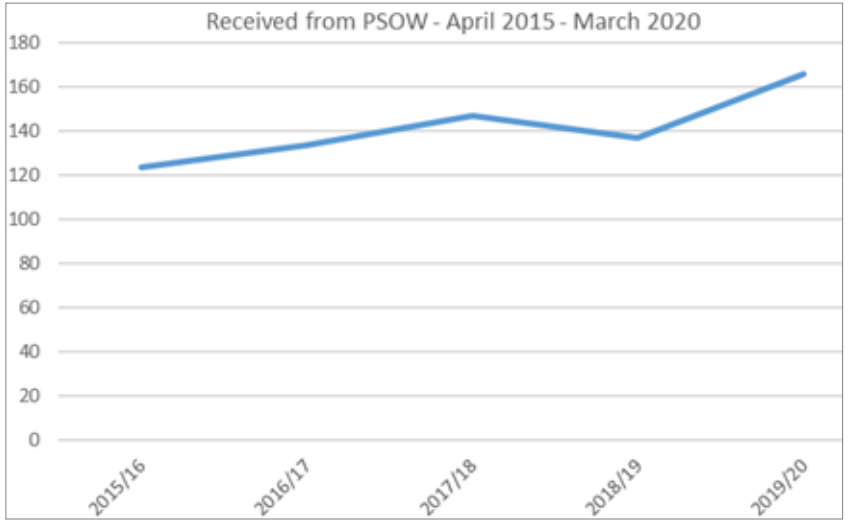
If a complainant is not satisfied by the Health Boards response to their complaint, they can ask the Public Service Ombudsman Wales to undertake a further independent investigation.

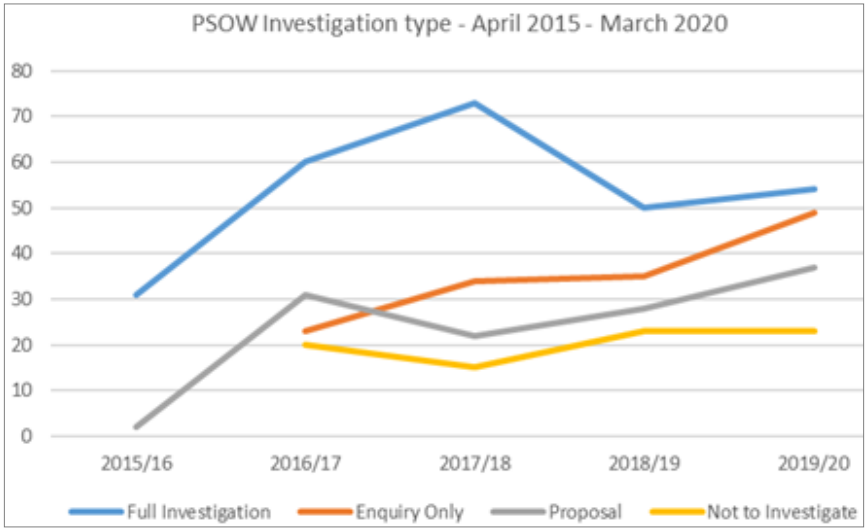
As shown in the first chart (left) below, in 2019/20, **166** complainants made the decision to approach the Ombudsman.

Of those 166 cases, the Ombudsman decided to fully investigate **54** cases, **49** enquiries were received where the Health Board were requested to provide PSOW with information, **26** cases were not investigated by the Ombudsman and **37** were dealt with as a Proposal where the Heath Board agreed to carry out specific actions in order to resolve outstanding issues. These figures are reflected in the second chart below (right).

As you can see, these figures are higher than 2018/19, when 137 people approached the Ombudsman who decided to investigate 49 cases. During 2017/18, 146 people reported their case to the Ombudsman with 70 cases being investigated.

Of the 54 cases investigated during 2019/20, 5 have been either fully or partially upheld and 6 were not upheld. Information on the remaining 32 cases has not yet been received from the Ombudsman's who continue with their investigations.





Further details of the cases reviewed by the Ombudsman will be available online in the Public Service Ombudsman for Wales Annual Report at: https://www.ombudsman.wales/annual-report-accounts/

Public Interest S16 Cases

The PSOW does not routinely publish his reports, however, where there is significant concern regarding the matters investigated, the PSOW will issue a Public Interest Section 16 (S16) report. An S16 report provides the Ombudsman with the power to investigate alleged maladministration or failure in a relevant service provided to a person or an alleged failure to provide a relevant service to a person.

BCUHB received two public interest Section 16 reports during 2019/20 when the Ombudsman found serious failings, however one of the Section 16 reports was reconsidered and retracted by the Ombudsman and subsequently issued as a non-public interest Section 21 Report. As such, these reports are anonymous and have no identifiable details, therefore cannot be identified. No Section 16 reports were received during 2018/19.

Expanded Ombudsman Powers

Changes to the Ombudsman jurisdiction came into effect from 23 July 2019, following the implementation of the Public Services Ombudsman (Wales) Act 2019 ("the new PSOW Act"). The Ombudsman can now consider complaints where a private healthcare provider has entered into contract arrangements with Health Boards to deliver certain services and is now able to directly investigate a complaint about the clinical care.

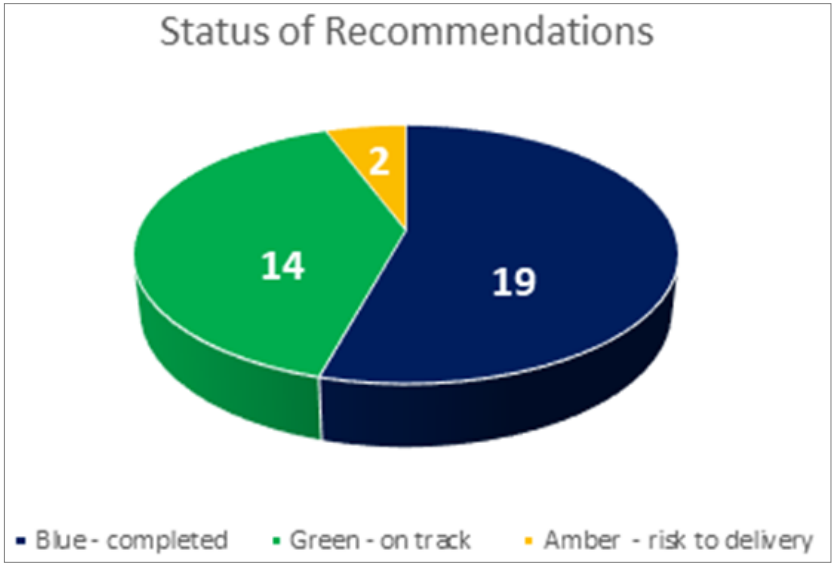
Under the new PSOW Act, the Ombudsman is also able to conduct his own initiative investigations, which can extend an investigation to include consideration of actions by a body not already complained about. Under the new PSOW Act, no Health Board complaints have been investigated within the new Ombudsman powers.

HASCAS & Ockenden Improvement Work

In September 2015, the Health Board commissioned HASCAS Consultancy Limited (now Duncan & Johnstone Limited) to lead an independent investigation in relation to the complaints, concerns and professional regulation and employment issues arising from the significant failings in care on Tawel Fan ward.

HASCAS published the Lessons for Learning Report on 3 May 2018, which provided the Health Board with a full, evidence-based view that is the result of a comprehensive investigative process, which included over 100 interviews of families and staff. The Ockenden Review of Governance Arrangements published in July 2018 provided an independent governance review relating to Tawel Fan ward, prior to closure and current governance arrangements in older people's mental health.

The recommendations were accepted by the Health Board, and Gill Harris Executive Director of Nursing & Midwifery, established a taskforce comprising an Improvement Group and a Stakeholder Group in August 2018. The Stakeholder Group meets on a quarterly basis and Stakeholder members have engaged directly with operational leads and respective working groups established for some of the recommendations, which have made valuable contribution to the work of some of the recommendations. The Stakeholder Group has also received presentations from operational leads on a number of the recommendations to provide detailed progress updates.



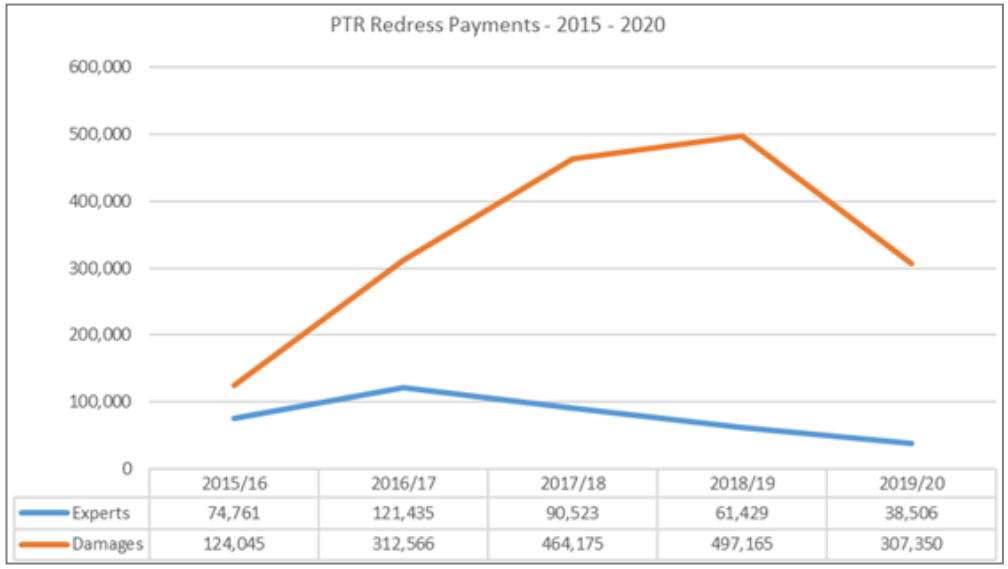
Progress against recommendations

Progress has been made for the **35** HASCAS and Ockenden recommendations;

- **19** now having been signed off as fully implemented
- Out of the 16 that remain open **14** are on track to deliver **2** are in progress which require some additional focus or support to address some challenges.

Progress updates are reported to the Quality, Safety and Experience Committee bi monthly and to the Board quarterly for scrutiny and assurance.

Redress



Whilst the Health Board always strives to ensure it delivers the best possible care and treatment, sometimes things may not go as well as expected. When that happens, there are Regulations which the Health Board must follow to consider whether what has gone wrong has caused the patient any harm. If it has, we have a duty to try to make it better. This is called Redress, and can include one or more of the following:

- a full explanation of what happened
- an apology
- an offer to provide care or treatment (where appropriate)
- a report on action which has been, or will be taken to prevent similar cases arising
- and/or financial compensation (maximum £25,000).

The Health Board concluded 80 cases under the Putting Things Right (PTR) Redress Regulations in 2019/20 compared to 94 during 2018/19:

- Financial compensation as redress - 38
- Apology only as redress - 8
- Cases which became clinical negligence claims – 24
- Concerns where it was considered the financial redress allowed under PTR would be exceeded – 10

Learning from Redress cases

For each case where something has gone wrong and it has caused harm, evidence of action taken in an endeavour to reduce the risk of recurrence had to be provided to the Welsh Risk Pool. Examples of learning from the redress cases concluded within 2019/20 are as follows;

- **Sepsis was not dealt with quickly enough and antibiotics should have been administered sooner:**
  Work has been undertaken, led by the Office of the Medical Director, to improve the knowledge and practice of both nursing and medical staff in relation to sepsis.

- **Name and address label sheet was placed into the back of the wrong patient's clinical notes:**
  Following this incident staff have been reminded of the importance of checking personal data to ensure that it is correct for that patient. The Health Records team have also reminded staff of the importance of checking patient data when setting up case notes and preparing them for clinic.

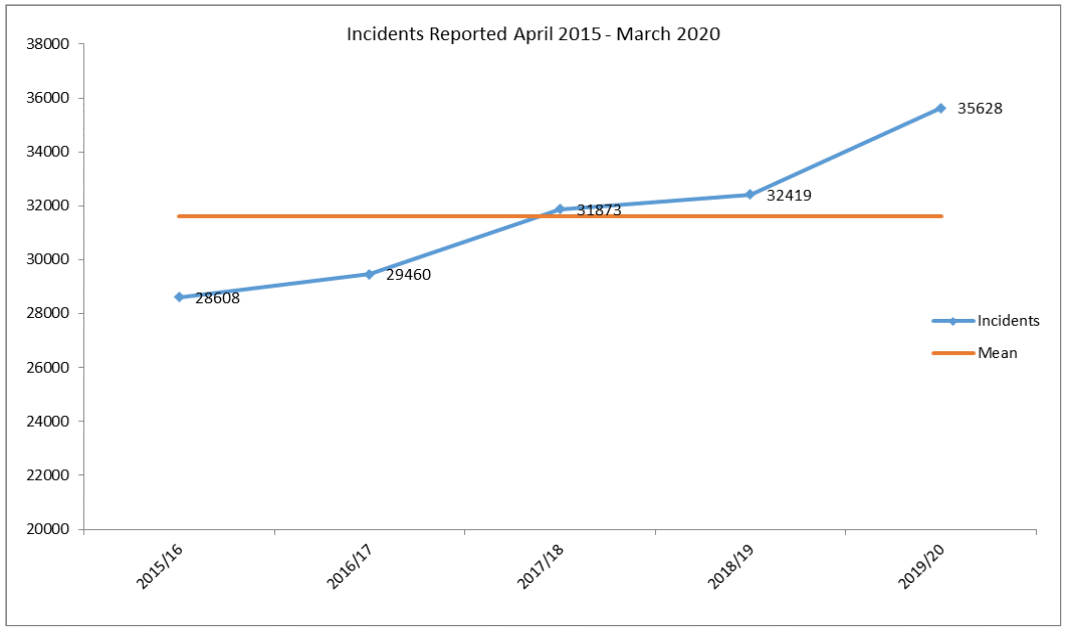
- **Delay in the Emergency Department the patient was not reviewed by a doctor until an unfortunate fall:**
  A new Emergency Department policy and documentation has been developed that incorporates falls assessment, frailty score and risk assessment for pressure ulcers.

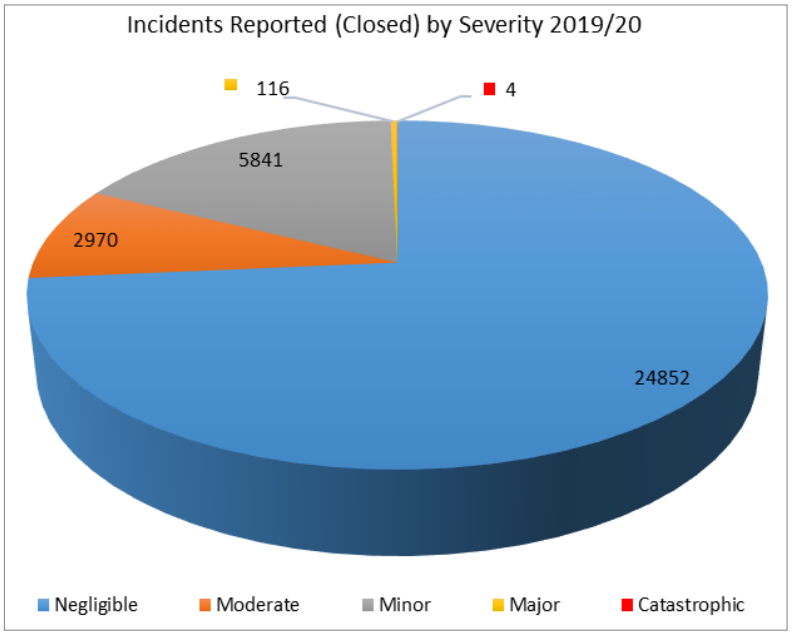
- **Failure to identify a tumour on a scan which lead to delay in diagnosis:**
  Scan images were reviewed at the Radiology learning meeting to share the learning. The pathology department have added an additional checking process to ensure requests for tests are made, and followed up, in a timely way.

- **Incorrect advice given over the telephone to patient with history of diarrhoea review of a patient's medical history and the medication list, which included diuretics (water tablets):**
  The Health Board issued a revised and re-dated Acute Kidney Injury (AKI) guidance leaflet to all Healthcare Professionals in North Wales for patients with AKI or those who are considered to be at risk of AKI and the action to be taken in such situations.

Incidents

Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patients receiving healthcare. Incidents are reported on Datix (an electronic incident reporting system), the integrated risk and safety management system used by the Health Board. Incidents are reviewed at site and area level via their respective Quality and Safety sub groups. In addition, management of incidents are scrutinised and monitored at a monthly Quality & Safety Group which is chaired by the Executive Director of Nursing.





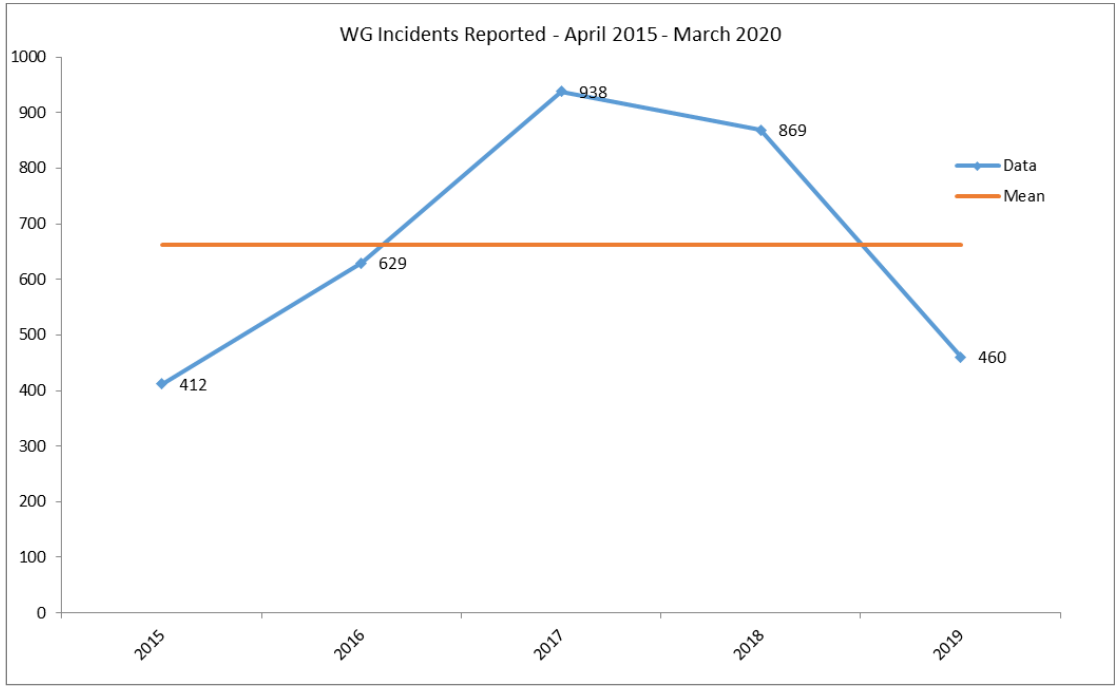
The run chart shows an increase in incident reporting year on year. The Health Board actively encourages all staff to report any patient safety incident including those categorised as near misses. Incident reporting is considered to be one of the mechanisms that the Health Board utilises to gain learning and drive improvements.

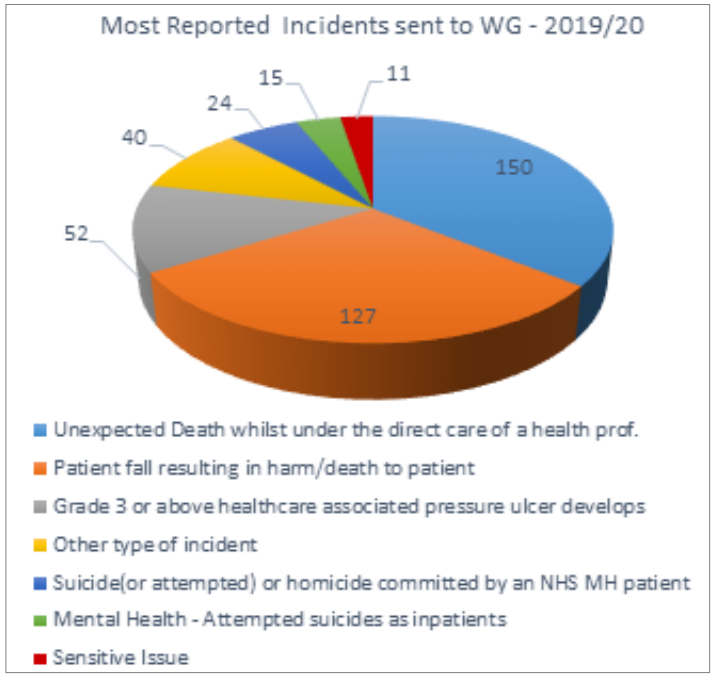
The pie chart shows the number of incidents reported by severity during the year 2019/2020. The chart shows only those incidents that have been closed following investigation, but illustrates that the majority of incidents reported are classed as negligible (no harm) incidents or minor (low harm) incidents. Any incidents that have caused significant harm are also reported to the Welsh Government and are managed via the organisation's serious incident process.

Welsh Government Reportable Incidents

Welsh NHS bodies are required to report all serious patient safety incidents to the Improving Patient Safety Team of the Welsh Government (WG) within 24 hours of the incident.

For the period 2019/2020, there has been a total of 460 serious incidents reported to Welsh Government. This is a 47% reduction compared with the previous period 2018/2019.





Never Events

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

Since April 2010, all serious incident notifications have been reported electronically to the Improving Patient Safety Team Mailbox at the Welsh Government. This should be done with 24 hours of the incident. The Welsh Government respond within 24 hours and set-out a grade of the incident.

During the period 1 April 2019 to 31 March 2020, a total of **6** Never Events were reported to Welsh Government; **4** Never Events have been closed and **2** remain open as they are subject to ongoing investigation.

The key learning points from these completed investigations are set below.

Learning

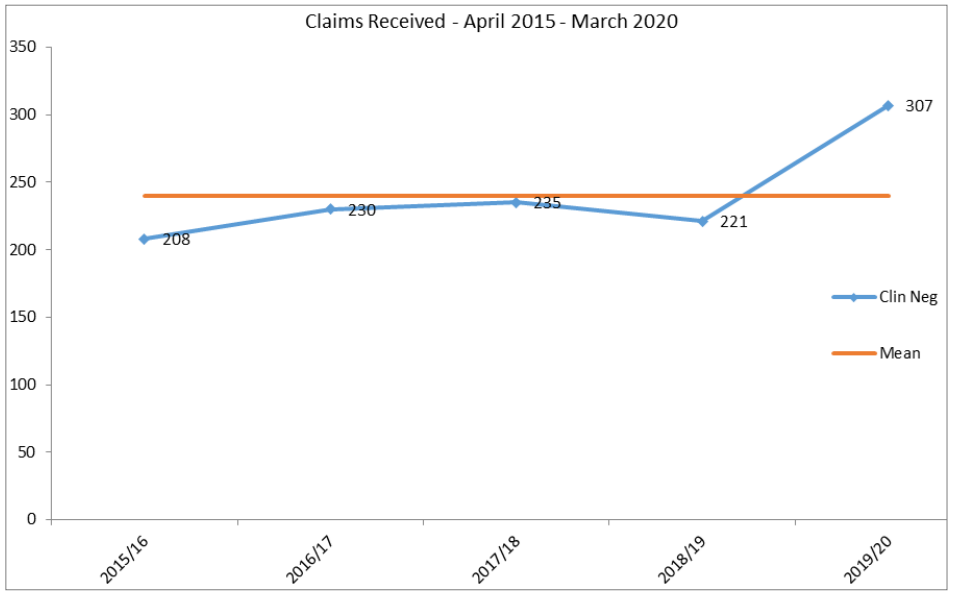
- Peripherally inserted central catheter line (PICC) lines should only be inserted if no alternative and a register of PICC line insertions is now held.
- Visual prompts to ‘stop before you block’ added to Theatre trollies and World Health Organisation checklist training update has been completed including Stop Before You Block. An updated Induction form for all new or visiting Theatre staff to include ‘stop before you block’ to raise awareness is now in place.
- Emphasising the importance of marking of the site/area to be injected
- Out of Hours Patients are transferred to Intensive Care Unit (ITU) for PICC line commencement
- Second check of referrals (that are not completed during clinic appointment with the patient) reviewed and revised

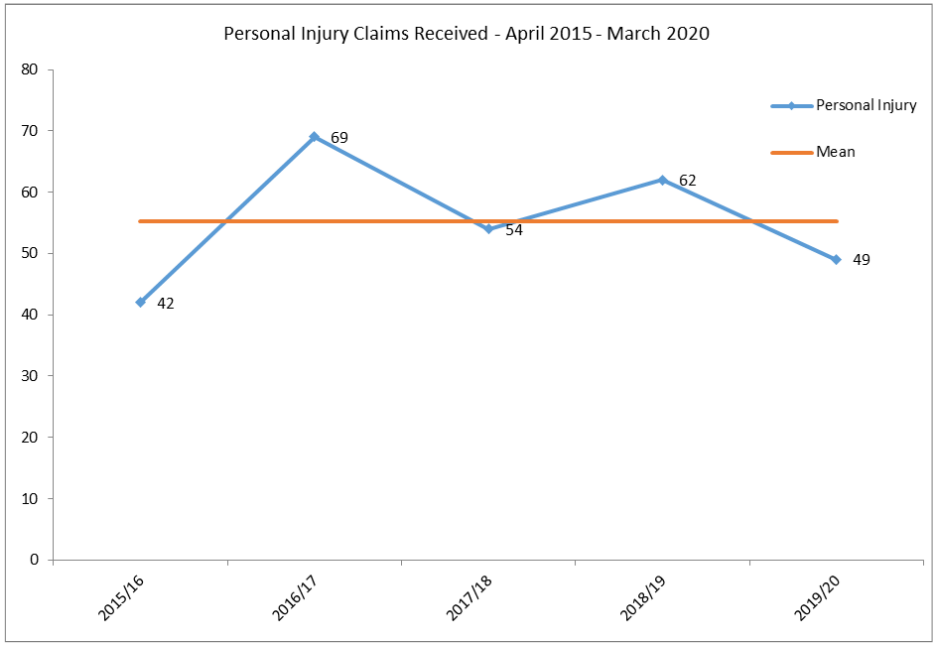
Claims

The Health Board has a legal duty of care towards those it treats, together with members of the general public and its staff. People who consider they have suffered harm from a breach of this duty can make a claim for compensation and damages against the Health Board, by way of either:

- Clinical/medical negligence claims
- Personal injury claims

Clinical Negligence and Personal Injury claims are managed by the Health Board on the basis of legal advice provided by NHS Wales Shared Services Partnership Legal and Risk Services. The Welsh Risk Pool (WRP) will reimburse the Health Board for all losses incurred above an excess level of £25,000 on a case by case basis, if the Health Board can evidence learning. As shown in the charts below, there have been a total of **356** new claims opened for the period 1st April 2019 - 31st March 2020.





Of the new claims opened **307** were Clinical Negligence and **49** were Personal Injury claims. Of the 307 Clinical Negligence claims the following themes have been identified during 2019/2020:

1. Implementation of care
2. Diagnosis – Including delay in diagnosis
3. Treatment or procedure

As expected, the largest number of open claims related to Surgery, Specialist Medicine, and Women and Maternal Care. This is not an unusual profile of specialities within the NHS. There is also a number of cases categorised as 'no value' which relate to Disclosure Requests/Pending Claims and the Claims Team have been unable to categorise them due to the limited information provided by the Claimant Solicitors.

Of the 49 Personal Injury claims the following themes have been identified during 2019/2020, with a rise in the numbers of claims relating to the following:

1. Data Breach
2. Occupational Stress
3. Needlestick

Other categories remain steady with the exception of lifting which has decreased.

Open Claims

There has been an increase in the number of claims received by the Health Board in 2019/20. Following the introduction of GDPR, Claimant Solicitors can now request copy records without having to pay a fee, which has led to an increase in the number of firms requesting records to investigate potential claims.

Learning

Revised WRP Case Reimbursement Procedures came into effect on 1st October 2019. The procedures were revised to align the various schemes that WRP administer reimbursement of and to ensure the introduction of earlier scrutiny of learning to 60 working days from decision to settle a case in an endeavour to reduce the risk of recurrence.

The new WRP procedures introduce a Learning from Events Report (LfER) and a Case Management Report (CMR). These are used by the Health Board to report the issues that have been identified from a claim and to determine how these have been addressed in order to reduce the risk of reoccurrence and reduce the impact of a future event. The trigger for an LfER is related to the date of a decision to settle a case (even if the loss incurred is under £25,000) and the Health Board has sixty working days to submit a report from this date. A CMR is then submitted four months after the last payment on a claim is made, detailing how quantum was decided, if delegated authority was used and confirming that senior leaders have been advised of the claims. The LfER needs to provide a sufficient explanation of the circumstances and background to the events which have led to the case, in order for the WRP Committee to scrutinise and identify the links to the findings and learning outcomes. Supporting information, such as action plans, expert reports and review findings can be appended to the LfER to evidence the learning activity.

Claims Audit

A review of Welsh Risk Pool – Claims Management Standard was undertaken in accordance with the 2019/20 Internal Audit Plan. The systems and controls in place were reviewed and assurance was sought against Assessment Area 10 of the Welsh Risk Management Concerns and Compensation Claims Standard.

The level of assurance given as to the effectiveness of the system of internal control in place to manage the risks associated with Welsh Risk Pool Claims Management Standard was reasonable assurance.

Changes to Datix have been implemented by the Claims Managers which include new fields to monitor progress of LfER reports and the different stages of approval and reimbursement from WRP. This will assist in ensuring learning is captured and evidenced to improve patient care for the future.

Key achievements in claims

The Executive Team for the Health Board now have an enhanced view in the financial approval of claims. A report of cases where authority has been provided to agree liability and settle damages and costs has also been put in place and is sent to the Associate Director of Quality Assurance on a monthly basis. The Audit Committee also now receive a report on all claims settled over £50,000. This report is the first report of its kind and has been developed to strengthen governance procedures.

Claims Managers use their knowledge and discretion to ensure all decisions are made in the best interests of the Health Board in order to minimise the financial impact of claims.

Inquests

There are many reasons why the Coroner may hold an inquest when someone dies and the Health Board will provide evidence as requested by the Coroner. The relationship with the North Wales Coroners and their officers continues to develop, with the Heads of Patient Safety being the main Health Board point of contact. A standard operating procedure has been introduced across all three acute sites across the Health Board, to ensure a unified approach to assisting H M Coroner with their enquiries.

The table below shows the total Inquests received for the period 2019/20; **287** inquests were held in relation to patients under the care of the Health Board for the reportable period.

	Central	East	West	Total
Acute	81	67	18	
Mental Health	40	63	18	
Total	**121**	**130**	**36**	**287**

Coroner's Regulation 28 Reports

The Coroner has a statutory duty to issue a report to any person or organisation where it is their opinion that action should be taken to prevent future deaths in similar circumstance. These are known as "Reports on actions to prevent future deaths – Regulation 28"

The Health Board has been issued with **2** regulation 28 reports during 2019/20, which are sent directly to the Chief Executive for action. Each of these requires a formal response from the Health Board within 56 days outlining actions taken by the Clinical teams and managers to assure the Coroner that all areas of concern have been resolved.

Of the 287 inquests, there were 2 cases where the coroner was critical of the care provided and action has been taken to address these concerns.

Patient Experience

Patient 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 and clinically effective care. 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)

Patient Advice Liaison Support (PALS)

The PALS service are key to Patient Experience. The service was first piloted in the Centre region in July 2017 and following its success was rolled out to the East and West in April 2019.The PALS service is now fully operational, with teams based across the three regions of North Wales. This has vastly increased the capacity and effectiveness of the Patient Experience Service across BCUHB.

The PALS service continues to work collaboratively with a vast variety of agencies and work streams across all sectors, and has been seen to make exceptional, positive work in showcasing the service, promoting their work so that positive improvements can be made. This ensures that the voice of patients and people who access services are heard and made apparent in all arenas, such as; ICAN (supporting and working collaboratively with this service so as to promote and collect future feedback to influence future developments) Welsh Language Services (promoting the positive work this service provides in enhancing the use of the Welsh language in the hospital setting), Dementia Services (collecting powerful patient stories and ensuring that areas are dementia friendly), Paediatric and Community Services (networking positively so as to engage with patients to collect valuable feedback, ensuring paediatric services in the community can be improved), Paediatric ward in Ysbyty Glan Clwyd (YGC) (supporting the use of the High 5, Low 5 so as to support the collection of feedback from children admitted to this ward).

Social Media

In line with a need to promote and publicise the work by carried out by the Patient Experience Team, the service have created a Twitter page account, promoting the positive work and developments to the service across BCUHB and to the public. Regular tweeting of events, enhancing our profile and the good work that is carried out across each service area, and ensuring that all information and any new developments are regularly tweeted by the team.

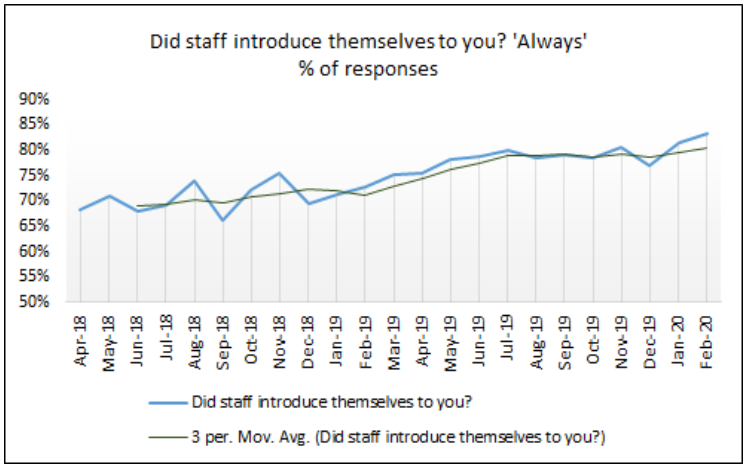
All the information regarding the Patient and Service User Experience team is presently being added on the intranet page, and presently being developed into categories that will be accessible for all those within BCUHB to read. It will have collective relevant information that is up to date, highlighting our strategy, our vision and our goals. It has information on patient stories, with a library of those collected by the PALS, Accessible Health Care, Learning material, and more recently, information regarding COVID 19, and the new Bereavement liaison support that we as a service provide.

Feedback

In line with the Assuring Service User Framework, the Patient Experience Service are striving to improve the quality of care by analysing, reporting and acting on the feedback and data received. The reporting of this feedback collected depends on the method for gathering data, which is from patient stories, care2shares consultations or the real time feedback surveys, and is provided quarterly on patient satisfaction in regards to PTR.

The feedback that is reported back demonstrates the overall performance of that service within the Health Board, as well as highlighting areas in need of improvement. This feedback can then escalated within the different departments. Additionally areas of good practice are also shared, and can be adopted across the whole of the Health Board. We can then encourage these areas to take ownership of identified variations in care, act upon them, and welcome feedback on the improvements that have been implemented.

The response rates in the graphs below demonstrates the data collected for the three acute hospitals across BCUHB, inclusive of the data for respective community hospitals. When compared to the previous quarter, this data shows that there is an improvement in performance across the board in relation to all of the questions where the response was given as ‘Always’. The questions asked were: Did the staff introduce themselves? Do you feel that you were listened to? Did staff take the time to understand what matters to you? Did you get assistance when you needed it? Were you involved in decisions about your care? Were you given all of the information you needed?


Did staff introduce themselves to you? 'Always'
% of responses
90%
85%
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May-18
Jun-18
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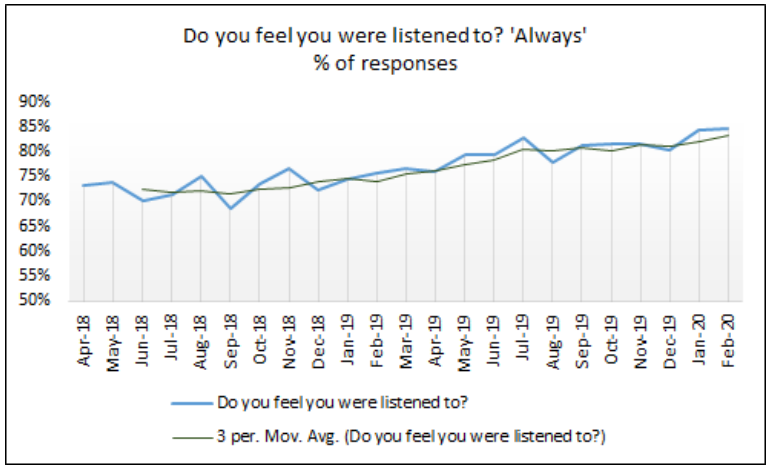
Did staff introduce themselves to you?
3 per. Mov. Avg. (Did staff introduce themselves to you?)


Do you feel you were listened to? 'Always'
% of responses
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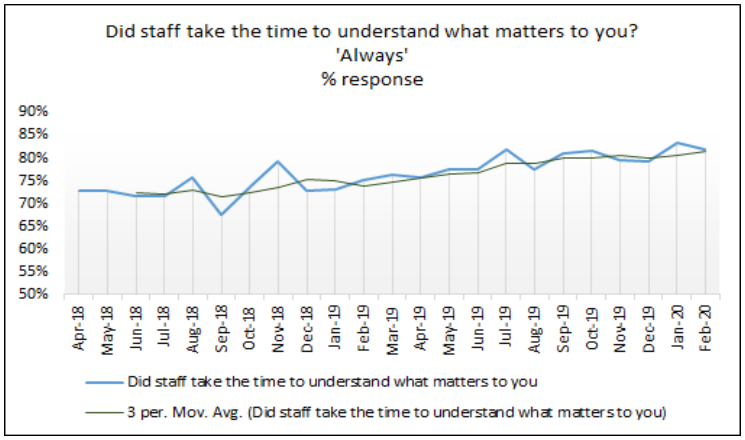
Did staff take the time to understand what matters to you?
'Always'
% response
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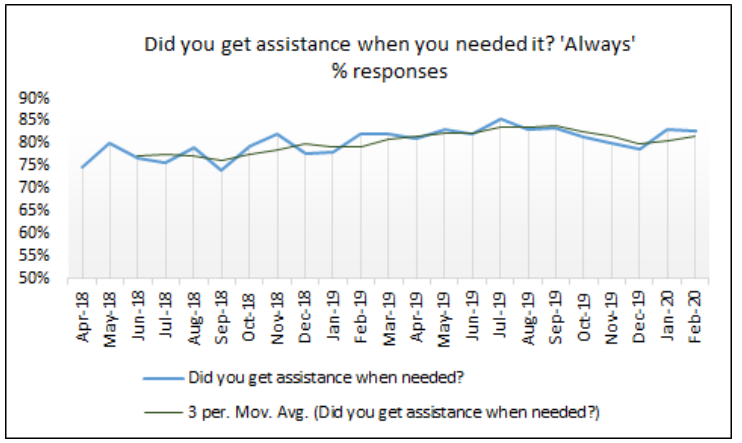
Did staff take the time to understand what matters to you
3 per. Mov. Avg. (Did staff take the time to understand what matters to you)


Did you get assistance when you needed it? 'Always'
% responses
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Feb-20
Did you get assistance when needed?
3 per. Mov. Avg. (Did you get assistance when needed?)

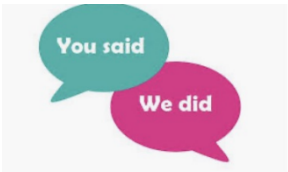
Welsh Language

The Health Board has continued to make progress in implementing its Welsh Language Scheme, with the focus now progressed to the implementation of the Welsh Language Standards under the Welsh Language Measure 2011. The Welsh Standards became applicable in May 2019.

A new Bilingual Services Monitoring Scheme was initiated in March 2018, to scrutinise the availability and quality of Welsh-medium services across the Health Board. 'Could you speak Welsh if you wanted to?' was introduced in May 2019 as a new question to the patient feedback survey to comply with the Welsh Language Standards. The figures are also gathered on a monthly basis by the Patient Experience service, and can be reported upon regularly so as to monitor the use of Welsh whilst patients stay in hospital.

There is a fluctuation across the West, Centre and East regions regarding satisfaction concerning whether or not service users were able to use the Welsh language if they so wished. Actions to improve compliance regarding the Welsh Language Measure includes an increased staff awareness of the requirement to offer the provision of services through the medium of Welsh, ensuring that the arranging of staff rotas takes into consideration the need to ensure we have sufficient Welsh speaking staff on different shifts, and evaluation of the language requirements for new staff posts.

You Said We Did



The Patient Experience Team reports on comments queries and questions raised, and report and feedback on what services have done to resolve these issues. We are therefore committed to provide more opportunities for service users to have their say so that positive changes can be made.

Based on reported patient experience feedback, all service areas identify emerging key themes that encompass positive feedback in their services and also those areas that patients and service users felt needed improvement. The service areas were then asked to provide detail of the changes proposed so as to facilitate the improvement to happen. A few examples of positive and negative sub themes from different service areas across BCUHB are seen below, reviewing key sources from real time feedback systems, patient comment cards, patient stories, care2shares, complaints and incidence trends, compliments and local surveys.

You Said…….	We Did…….
NEUROPHYSIOLOGY, NW MANAGED CLINICAL SERVICES DIRECTORATE: Positive: Compliments from service users and Medical practitioners to specific clinicians for their compassionate care in particular with vulnerable clients. Negative: difficulties in locating department, lack of signage	**Action-** Compliments feedback to those concerns, so as to introduce best practice, video observations utilized to improve communication skills. **Action-** Revised bilingual maps and directions mailed out to all patients. Regular reminders sent to estates to complete all outstanding work. Informed patients of current limited accommodation and plans on Maelor site to refurbish these areas so as to reintroduce services
WREXHAM MAELOR, SECONDARY CARE Positive: Staff attitude and across all areas. Compassionate, person centred care. Time for patient education regarding long term conditions. Negative: Long waiting times in ED, Access to planned care, staff attitude, dementia friendly environment, broken facilities, and level of noise at night.	**Actions:** Team, department and individual monthly recognition award implemented at monthly leadership forum. Celebration of 'Feel Good Friday'. Positive comments and reports recorded by PALS. **Actions:** New acute medical model introduced. Review of ED Medical and Nursing workforce. ED to implement planned care so as to ensure an improvement in the care delivered. Protection of arrivals unit from escalation. Roll out dementia friends training. Review of charitable funds to provide additional resources for patients. Reduce the moving of patients between wards during unsociable hours. PALS to provide a presence in ED.

COVID-19

Patient Experience Bereavement and Liaison Support

As a consequence of the Covid-19 pandemic, the Patient and Service User Experience team have embraced new ways of working.
During the Covid-19 pandemic it is anticipated that the volume of families BCUHB Bereavement Officers will be supporting will increase, to support this service Patient Experience have developed a bereavement and liaison support service. The aim of the service is to listen, offer advice and support to patients, families, carers, and to liaise with staff and other organisations to facilitate additional support.

Links have been established within the Health Board in order to form an extensive support pathway for bereaved families. Referral forms have also been developed for the Chaplaincy and volunteer services. Partnerships are continuing to form with third sector agencies which will enable us to signpost effectively to the relevant agency to provide additional continued support for our service users. A 'Here to Help With Your Bereavement' booklet has been revised to include information surrounding COVID-19 and is now available to read online and is accessible in British Sign Language. In addition, following a successful funding application to Awyr Las, training and additional resources will be available to support the team. Promotional material, memory boxes, condolence and prayer cards along with reflective gardens are one of many developments in progress.

So far we have engaged with a total of **28,906** individuals via social media. The service has also received 588 views on our webpage, 213 Facebook views, and 91 enquiries direct to the service.

Letters to Loved Ones

During the Covid-19, visitors to hospitals have been restricted which is why 'Letters to Loved Ones' has been established to maintain communication between loved ones and patients. This means that a message can be sent via email or passed over the telephone and that message will then be delivered to patient on the wards. A total of 315 requests have been received as at June 2020.

So far we have engaged with **30, 283** individuals via social media. The service has also received 2,814 views on our webpage, 1,740 Facebook views and 494 enquiries direct to the team.

The Patient Experience team have received some heartfelt feedback from loved on who have used our service;

> "I would like to thank you for passing our emails on to our loved ones. You are all wonderful. It is so difficult for the patients not to have visitors, at this time and likewise, we cannot visit. Your service is a lifeline which I for one is so happy about. Cards and letters are not really reliable at this time. My brother is in Glan Clwyd. Many thanks. My clapping and whistle blowing on Thursday at 8pm will be especially for you. God bless. Best wishes to you all."

Make it Safe

In March 2020, the requirements for Welsh Government reporting changed in response to the onset of the COVID-19 pandemic. This meant that many incidents that would have been previously reported to Welsh Government were no longer a requirement; for example a fall resulting in harm.

In addition, the need to socially distance, work from home where possible and due to the increased workload pressures on clinical staff, serious incident reviews became more of a logistical challenge. In order to ensure the safety of patients and to identify learning at the earliest opportunity following a serious incident, a "Make it Safe" process was introduced into the Health Board. This process requires a review of the incident within 72 hours to ensure that anything that is required to make the situation safe is undertaken immediately and learning identified.

The completed "Make it Safe" documentation (for every serious incident) is submitted to the Associate Director of Quality Assurance and to the Head of Patient Safety for independent review. It is at this review that a decision is reached on whether the learning is appropriate and if further investigation is required.

Incidents are scrutinised and monitored at a monthly Quality & Safety Group which is chaired by the Executive Director of Nursing.

LOOKING FORWARD: AIMS & PRIORITIES FOR 2020-2021

Our Aims and Priorities for 2020-21

A key focus of the Patient Safety and Experience Department in 2020/21 will be developing and implementing a learning framework and associated tools that support an emerging learning culture. Work is underway currently to develop initial basic tools including a new Patient Safety and Experience Newsletter and Online Learning Portal to support the sharing of learning across the Health Board. The PTR1a concerns procedure is currently under review into a single, simplified and easier to read document alongside the process reviews mentioned throughout this report.

The Patient Safety and Experience Department is planning a comprehensive review of the concerns process collectively, and this will be conducted in co-production with divisions, patients and carers and other stakeholders which include;

- North Wales Community Health Council
- Public Services Ombudsman for Wales
- H M Coroner
- Legal and Risk Services from the NHS Wales Shared Services Partnership

This work commenced in March 2020 and is coordinated by way of a Delivery Plan which will help to ensure the delivery of the changes in a timely manner.

Running parallel to this will be the development and implementation of the new Datix IQ Cloud system and implementation of the anticipated Duty of Candour and a new national Serious Incident Framework which is currently under review. The work underway in the Health Board will place a significant focus on human factors/ergonomics and system thinking approaches to investigations rather than a focus on root cause analysis, and the enhancement of a just culture based approach.

Our updated strategies which include the Patient Safety, Patient Experience and Quality strategy, will strengthen the outcomes of our work and aid future improvement work and engagement.

USEFUL INFORMATION

Thank you for taking the time to read this report. If you have any queries, would like to request further information in relation to this report, or of you would like to keep up to date with news in relation to our services, please visit our website. Details of how to contact our Patient Safety and Patient Experience Team can be found at the 'Contact Us' page.

Our website https://bcuhb.nhs.wales/

Public Service Ombudsman for Wales

The Public Services Ombudsman for Wales has legal powers to look into complaints about public services and independent care providers in Wales. The Ombudsman also investigates complaints that members of local government bodies have breached their authority's code of conduct. He is independent of all government bodies and provides a free and independent service.

https://www.ombudsman.wales/

North Wales Community Health Council

The North Wales Community Health Council (NWCHC) is the independent health watchdog for North Wales. It represents the interests of patients and the public who use our health services. There are times we all need help to speak up about concerns/complaints if we – patients, carers, relatives – feel let down by our local health board or social care service. The NWCHC Advocacy Service can help raise those concerns/complaints through its role in providing a free, independent, confidential, non-legal, client-led service. NWCHC are able to help patients or their representative in making a complaint under the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

http://www.wales.nhs.uk/sitesplus/900/home

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**DRAFT : BCUHB Annual Quality Statement (AQS) 2019 / 2020**
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Erika Dennis Business Manager, Corporate Nursing
Craffu blaenorol: Prior Scrutiny:	AQS Editorial Group monthly meetings (January 2020 to March 2020) Stakeholder Reference Group 3 March 2020 Audit Committee 19 March 2020
Atodiadau Appendices:	Appendices A to C noted in "Recommendation"

Argymhelliad / Recommendation:

The Committee is asked to note Appendices A and B, and to discuss Appendix C;

1. Annual Quality Statement Editorial Group, Terms of Reference (ToR)
   Appendix A
2. Welsh Health Circular titled "Annual Quality Statement 2019 / 2020 Guidance" Welsh Government
   Appendix B
3. Annual Quality Statement 2019/20 first final draft
   Appendix C

The Committee is asked to take into consideration the fact that prior scrutiny has been challenging due to Covid-19. Any content under development has been highlighted as 'In Progress' and some information is due to be received (i.e. links, data). It is important that attention is given to content and not formatting at this point in time. The second final draft will be reported to the committee for approval on 14 August 2020.

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

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

Sefyllfa / Situation:

The purpose of this paper is to provide an update, to the Board/Committee in relation to the progress made with the Annual Quality Statement (AQS) 2019 / 2020 and to request discussion for the first part of the final draft (part one of two).

On 23 December 2019, the Health Board received confirmation from Welsh Government that the AQS was scheduled to go ahead for 2019/20. The plan of work commenced and Editorial Group members were approached and proforma's were issued to various services to complete with examples of good practice.

The Editorial Group initially met on 21 January 2020 and agreed the ToR (same as last year) **Appendix A**, and reviewed the Welsh Health Circular from Welsh Government, **Appendix B**.

Prior to Covid-19, the AQS 2019 / 2020, **Appendix C**, was scheduled to be reported to the following meetings/committees;

- Stakeholder Reference Group 3 March 2020
- Quality Safety Group 13 March 2020 (cancelled due to Covid-19)
- Healthcare Professionals Forum 13 March
- Quality Safety & Experience Committee 17 March 2020 (deferred due to Covid-19)
- Audit Committee 19 March 2020
- Local Partnership Forum 07 April 2020 (cancelled due to Covid-19)

With the final draft noted at;

- Quality Safety Group 30 April 2020 (cancelled due to Covid-19)
- Quality Safety & Experience Committee 05 May 2020 (deferred due to Covid-19)
- Board 14 May 2020 (deferred due to Covid-19)

The final approved AQS 2019 / 2020 would then be published on 31 May 2020.

Revised Cycle of Business

- Quality Safety & Experience Committee 3 July 2020 and 28 August 2020
- Audit Committee via Chairs Action (following QSE in August)
- Board 10 September 2020

On 27 March 2020, the revised timeline for the AGS/AQS/Annual Report/Accounts was confirmed by the Acting Board Secretary. As such, the new publication date for the AQS is 30 September 2020. The Health Board's Welsh Translation team are aware of the revised publication date and cycle of business. Internal Audit are due to review the AQS on 22 July 2020.
Progress with the AQS has been challenging due to the lateness in receiving the Welsh Health Circular **Appendix B**, and due to the pressures of Covid-19. This has also impacted the level of engagement.

In addition, the Board/Committee are asked to note that the Communication Team has monitored engagement levels with the AQS and the last version in 2019, has received no views on our website. Almost all of the information included in the AQS is already (or will be at the time of publication), available elsewhere. This feedback has previously been shared with Welsh Government as there does not appear to be a demand there and producing the AQS costs the Health Board in time and resources.

However, the AQS is a requirement and a good opportunity to reiterate all the good work that has taken place in 2019 and improvements for the Health Board. To date, a great deal of information has been received across the Health Board and the AQS will confirm how we engage and communicate this work all year round. Over the coming weeks, the editorial group members will meet again to review the AQS and to approve the second final draft.

Feedback from Audit Committee on 19 March 2020, was to incorporate Covid-19 in to the AQS, this is in progress. Clear signposting links will be added to the AQS and any gaps complete. Furthermore, the AQS will be aligned to the PTR Annual Report 2019/2020 (publication 10 July 2020) and also to the Annual Report (publication 31 August 2020).

Moving forward, future reporting for the AQS will change as per new reporting requirements in line with the Health and Social Care (Quality & Engagement) (Wales) Bill, which will build on and replace the existing AQS, as confirmed in the Welsh Health Circular.

Cefndir / Background:

The Welsh Health Circular, **Appendix B**, provides the background for the AQS.

Welsh Government draw particular attention to the Health and Social Care (Quality & Engagement) (Wales) Bill which includes a more broader duty of quality. In addition, the statement incorporates the *Health and Care Standards for Wales* and the *NHS Wales Outcome Delivery Framework*, providing an opportunity to include improvements the Health Board are making in line with *A Healthier Wales*.

There is also an element of looking back at what has been achieved in terms of progress against the priorities outlined in our Quality Improvement Strategy 2017-2020.

Asesiad / Assessment & Analysis

Strategy Implications

The statement will be aligned to the agreed strategic and business plans as it will incorporate progress against our strategic priorities such as Care Closer to Home, Excellent Hospital Care and Improving Health and Reducing Health Inequalities.

The statement will also look back on progress against the priorities outlined in our *Quality Improvement Strategy 2017-2020* and provide a forward look in accordance with our *Three Year Outlook and 2020/21 Annual Plan* echoing the 'Quadruple Aim' in the Parliamentary Review and A Healthier Wales. It will also align to the Putting Things Right Annual Report 2019/20.

Financial Implications

This report is purely administrative, there are no associated resource implications related to this report itself. There may of course be potential financial implications for each Division in terms of resource requirements but this report is not presented to consider these.

Risk Analysis

This report is purely administrative. There was an associated risk logged as an audit recommendation;

- *The AQS should be compiled and published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance*.

This status of which is now approved and closed as the AQS for 2019/2020 covers all key aspects of the Welsh Health Circular and as such, the report will be published covering key areas stated in latest WHC guidance and to properly reflect and convey Health Board services, achievements, improvements, challenges and performance.

Legal and Compliance

Compliance with Internal and External Audit requirements. The completion of the AQS is a requirement of Welsh Government and progress will be regularly reported to committees with the final version for the approval of Board on 10 September 2020.

Impact Assessment

This report is purely administrative. There will however be an EQIA (Equalities Impact Assessment) completed prior to QSE on 28 August 2020 and prior to publication of the AQS on 30 September 2020.

Betsi Cadwaladr University Health Board

Terms of Reference

Annual Quality Statement Editorial Group

1. ACCOUNTABILITY

The Annual Quality Statement Editorial Group is accountable to the Associate Director of Quality Assurance.

2. REMIT

To support the Executive Director of Nursing and Midwifery and Quality, Safety & Experience Committee in discharging their responsibilities for the production of the Annual Quality Statement.

3. CHAIR

Chair held by the Corporate Nursing and Vice Chair held by Corporate Nursing.

4. LEAD DIRECTOR

Executive Director of Nursing and Midwifery.

5. MEMBERSHIP

Members

Corporate Nursing Team (Chair)
Primary Care representative
Service User Experience representative
Head of Performance Assurance
Communications Team Representative
Head of Equalities and Human Rights

6. AUTHORITY

6.1 The group are authorised to seek any additional information it requires from any employee of BCUHB and all employees are directed to co-operate with any request made by the Group.

7. Quorum and Attendance

7.1 Due to the tight timescale of this years AQS and feedback from the Editorial group, the group will review the AQS electronically/virtually and feedback comments within the time scale set by Chair once draft document available.

7.2 Any member of BCUHB staff can, where appropriate, be invited to be part of the Editorial panel by the Chair.

8. CONDUCT OF MEETINGS

7.1 Due to the tight timescales for publication the Editorial group will be conduct business electronically following development of a draft document to review and comment.

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9. RESPONSIBILITIES & FUNCTIONS

8.1 To provide leadership, commitment and operational support to the Annual Quality Statement process.

8.2 To co-ordinate the development of the BCUHB Annual Quality Statement.

8.3 To ensure systems are put in place to review and monitor the ongoing submissions of reports including developing and implementing a system for urgent escalation to Director of Quality Assurance.

8.4 To ensure the timetable for completion is adhered to and deadline for the production of the final document is met.

8.5 To ensure all information provided has been agreed through local governance processes relevant to the area work.

8.6 To ensure appropriate and relevant stakeholder engagement prior to publication of the final document.

8.7 To ensure final publication of the Annual Quality Statement within the Welsh Government timescales in adherence with guidance available at time of publication.

10. REPORTING

9.1 Issues of significance from the Editorial Group will be escalated to the Director of Quality Assurance throughout the process of the development of the document.

11. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions which would normally be made by the Editorial Group need to be taken in between correspondence. In these circumstances, the Chair, will update the Director of Quality Assurance.

DATE OF ACCEPTING THE TERMS OF REFERENCE AND APPROVAL

Date:

Chair of Group signature:

WHC/2019/042

WELSH HEALTH CIRCULAR

Llywodraeth Cymru
Welsh Government

Issue Date: 23 December 2019

STATUS: INFORMATION

CATEGORY: QUALITY & SAFETY

Title: Annual Quality Statement 2019 / 2020 Guidance

Date of Expiry / Review March 2021

For Action by:
NHS Wales

Action required by: 29 May 2020

Sender: Jan Firby
Healthcare Quality Delivery
Population Healthcare

DHSS Welsh Government Contact(s) :
Mandy Stone
Population Healthcare
Health and Social Services Group
Welsh Government
Cathays Park
Cardiff
CF10 3NQ

Enclosure(s): Annual Quality Statement 2019-20 Guidance

The Annual Quality Statement 2019-20

1. Background

The Annual Quality Statement (AQS) provides an opportunity for organisations to 'tell the story' of good practice and initiatives being taken forward, as well as confirming what **went well** and what **not so well** and the **actions being taken as a result**. All NHS organisations are required to publish an AQS, as part of the annual reporting process.

NHS organisations need to be mindful that the Health and Social Care (Quality & Engagement) (Wales) Bill includes a new, broader duty of quality which requires NHS bodies in Wales to exercise their functions with a view to securing improvement in the quality of health services.

The Bill is at a relatively early stage in the Assembly's legislative scrutiny process. If the Bill is passed by the Assembly, we hope to bring the new duty into force in Summer 2021.

Detailed guidance will be developed with stakeholders to support its implementation. The Welsh Government will also supply training materials so staff are aware of the new duty and what it means in practice.

The Bill contains annual reporting requirements which require NHS bodies to assess the extent to which the steps they have taken to comply with the new duty of quality have led to improvements in outcomes. This new reporting requirement will build on and replace the existing Annual Quality Statement to form the basis of the mechanism through which the duty will be reported. Revised guidance will be co-produced ahead of the new requirements being introduced.

In the interim, annual quality statements will continue very much as in previous years but with an eye on the future requirements under the Bill. This Welsh Health Circular therefore provides guidance on the content and structure of the statement for 2019-20.

2. What should a Statement include and look like?

The AQS is for each organisation's resident population and provides an opportunity to let the public know, in an open and honest way, how it is doing to ensure its services are addressing local need and meeting high standards. Bringing together a summary highlighting what has been done to improve the quality of the services it provides and commissions, in order to drive both improvements in population health and the quality and safety of healthcare services. In developing the AQS it should enable LHBs and trusts to:

- provide an assessment of how well they are doing across all services, across the patient pathway, including social care and the third sector;
- promote good practice to share and spread more widely;
- confirm any areas which need improvement;
- build on the previous year's AQS, report on progress, year on year;
- account to its public and other stakeholders on the quality of its services; and
- engage the public on the quality of services received from their health board / NHS Trust to help inform the AQS content.

Engagement with the public will be important to understand what matters to them and what they would like to see in their local quality statements.

The statement needs to encompass all key themes in line with the *Health and Care Standards for Wales* and the *NHS Wales Outcome and Delivery Framework.* It also provides the opportunity to reflect improvements being made to services in line with the expectations set out in *A Healthier Wales*, the Social Services and Well-being (Wales) Act 2014 and the Well-being of Future Generations (Wales) Act 2015.

It should be presented in a way that can be understood by those who use the services provided, written in plain English and be jargon-free, using visual graphics to underline key messages. To ensure national consistency in approach, more detailed advice is provided in annex 1.

Organisational communications leads will need to work closely with their quality and safety colleagues to ensure the content and format of the statement is as would be expected of a public-facing report. We expect the communications departments to be actively involved and engaged with the promotion of the AQS through the use of internet, intranet and approved social network sites such as Facebook and Twitter.

A communications strategy should also be developed to aid publication and promotion of the AQS.

3. What does it need to cover?

The AQS should combine an element of looking back at what has been achieved with a forward look using data and information available for the reporting year. In looking back, LHBs and trusts should seek to answer the following questions:

- are we meeting standards and delivery requirements and are we improving outcomes, across the whole patient pathway?
- are we genuinely seeking to understand the patient/user experience and is it improving?
- are we meeting or exceeding our improvement goals?
- are we being open and learning from errors and concerns?

Examples of initiatives or work to demonstrate commitment to the following should also be included:

- Wales for Africa and other international health partnerships
- embedding a rights based approach which challenges ageist attitudes and stereotypes, making rights real in public service.
- mitigating risk in achieving high quality care and being honest about performance.
- identifying and celebrating areas of local innovation in service delivery and transformation to ensure spread and sustainable improvement
- integration and partnership working.

4. Publishing the AQS

As the AQS is a public document it should be presented in a way which is accessible to all. A bilingual AQS must be published electronically on organisations' websites, with hard copies being made available on request. Organisations should also take into account the needs of their local populations and consider making the statement available in other formats or languages where there is a need to do so, considering going beyond meeting the legal requirements in such matters.

Organisations may want to consider using a number of ways to 'tell the story'. This could be through a mix of case studies and patient stories as well as quantitative data presented clearly and succinctly, signposting the reader to more detailed or technical information as required. It should provide a balance between positive information and an acknowledgment of where services need to improve.

The AQS must be produced on a financial-year basis, which aligns with the financial and performance data reporting periods within NHS organisations' Annual Accounts. Statements must be published no later than **29 May 2020**, in line with the annual accounting and reporting timetable.

It is recognised that this can present difficulties in accessing timely data at the year end to meet publication deadlines. To overcome this it is suggested that quantitative information be presented in one of three ways, depending on data availability at the time of reporting:

1. If a full financial year of data is available, then data for the 1st April to 31st March should be included.
2. If a full financial year of data is not available, data for a calendar year, 1st January to 31st December, should be used to show performance trends supported by commentary on projected end of year delivery where possible.
3. If the measure is qualitative in nature or the data is not available either on a financial or calendar year basis then NHS organisations should provide commentary on past and anticipated end of year delivery. Cross correlation, where appropriate with your Annual Report is recommended to reduce duplication and to provide more collaborative approach.

5. Assuring the Annual Quality Statement

The Board is accountable for each organisation's quality statement and must therefore assure itself, through its internal assurance mechanisms, including internal audit, that the information published is both an accurate and representative picture of the quality of services it provides and the improvements it is committing to. The Chair and Chief Executive will need to include a statement confirming this. Organisations may also wish to include statements demonstrating engagement from other stakeholders, such as Community Health Councils and social care when agreeing their statement.

Annex1

Annual Quality Statement
Template for 2018/19

1. **Statement from the Chair and Chief Executive**

2. **Introduction**
   This section should set the context, describing the population needs of the organisation which have been identified and how these will be meet. Summarising the steps being taken to engage with its population and users and the improvement priorities set last year and any in-year challenges including unexpected events which may have influenced this.

3. **Looking Back Over the Past Year**
   This section should be set out in line with the individual themes below. It should aim to ensure a consistent national approach as far as possible, whilst at the same time providing the opportunity to reflect local priorities. When providing specific examples, it is suggested they are chosen to reflect the local context. **Not all of the areas set out below will be relevant to each organisation, so organisations should draft their response in the spirit of this guidance and adapt their content to suit the services or programmes which they provide.**

   Each theme should provide examples of achievements and improvements as well as challenges, including actions in response to any quality triggers or external reviews which may have taken place during the year. It should show how the organisation has listened to, learnt from and is working with all its partners including social care and the third sector.

   - **Staying Healthy**

   Examples of actions to promote and protect health – examples drawn from obesity, smoking, alcohol, exercise, immunisation rates etc. and/or examples of health improvement programmes implemented. Examples of innovative services in primary and community care to help people maintain good health and live independently.

   - **Safe Care (Services)**

   This section should specifically include examples of actions to improve safety, including nutrition and hydration, falls, pressure ulcers and progress in reducing healthcare associated infections. Progress and learning from case note mortality reviews and other sources of mortality data, serious incidents, safeguarding issues and independent reviews and descriptions of any never events and learning should be included in this section.

   - **Effective Care (Services)**

   Examples of achievements and challenges across individual service delivery plans in providing evidence based effective pathways of care, including efforts to ensure integration and joint working with social services. This section may

need to signpost to more detailed reports for some areas e.g. cancer, stroke, mental health, primary care, children etc. A few examples of participation and learning from national clinical audit, clinical outcome reviews and peer review. This could be linked to local improvement priorities also participation in and learning from research, development and innovation.

- **Dignified Care**

A summary of progress against actions agreed in 'Dignified Care', as well as examples of improvements or challenges which have impacted on meeting the needs and overall experience of patients with dementia, cognitive impairment or sensory loss. Summary of actions being taken to ensure the provision of good continence care, including improvement actions where needed. Improvements made following inspections undertaken by Healthcare Inspectorate Wales.

- **Timely Care (Services)**

A summary of progress and actions taken to improve timely access to and discharge from services including GP access, unscheduled care, ambulance handovers, delayed transfers of care and preventing late night/early hours discharges from hospital, working with social services where required. This could include a summary of participation in the national unscheduled care programme. Examples of actions taken to reduce risk of harm associated with delays in accessing services/care, including participation in the national planned care programme.

- **Treating People as Individuals**

Examples of services/care designed to meet individual need e.g. communication needs, sensory loss, disability and maintaining independence, supporting carers as well as improving services for vulnerable groups. Listening and learning from individual feedback, including the Evans Review of Putting Things Right (PTR) and progress and examples in implementing the National Service User Experience Framework. This should include or signpost to PTR data and learning.

- **Our staff**

A summary of the workforce profile and challenges e.g. actions taken to ensure safe staffing levels, tackle recruitment difficulties, etc. and numbers of and the support provided by volunteers. Examples of actions taken following staff feedback/surveys etc. Examples of actions to develop and support staff to deliver compassionate care and make improvements: including through the provision of training and development in areas such as dementia, cognitive impairment and sensory loss, as well as staff appraisal. This section should also include progress in embedding the Improving Quality Together Framework (IQT), individual and team awards.

The OPC also sets out 3 areas relating specifically to staff, including staffing levels, training and responding to the views of staff. LHBs and trusts should increasingly demonstrate how such issues are considered throughout the year

and how findings etc are brought together to support the evidence provided within the Annual Quality Statement. These expectations align with those set out within the Health and Care Standards Framework.

It is suggested the Wales for Africa disclosure is captured within this theme. You may wish to include reference to information such as the number of staff granted 'volunteering' time, number of staff otherwise engaged with health links work, or any international learning opportunities undertaken. This section also provides an opportunity to draw attention to any other wider strategic international links and projects, and to draw attention to activity undertaken locally to implement the principles of the Charter for International Health Partnerships in Wales:

http://www.internationalhealth.wales.nhs.uk/sitesplus/documents/1100/IHCC%20Charter%20for%20IHP%20%28Interactive%29%20E.pdf

4. Forward Look

This section should summarise how each organisation has used this process to identify areas for focus and improvement for the coming year, working with all its partners including social services. It should set out clear, measurable improvement actions against each of the themes above. It should also describe how the organisation will track progress during the year, including evidence from how it listens and learns to drive continuous improvement.

5. Engagement and Feedback

The document should also be seen as a tool for engagement and a key element in the organisation's communication strategy. Organisations are encouraged to engage with all their stakeholders or partners in agreeing the final statement and include any endorsements/engagement statements as appropriate. They should also include details of how the reader can contact the organisation to comment on the statement or to seek further information.

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

DRAFT

Annual Quality Statement

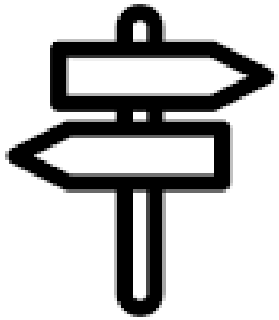
1 April 2019 to 31 March 2020

Health Improvement, Health Inequalities

Care Closer to Home

Excellent Hospital Care

Contents



Where is the information you want to know?

"The different colours represent the 7 areas of the Health Care Standards."

About this report

The Annual Quality Statement is an opportunity for us to share what we have been doing to improve the quality of our services over the last year. This report follows the format of the Health and Care Standards[1] themes:

Staying Healthy - you are well informed and supported to manage your own physical and mental health.
Safe Care - you are protected from harm and protect yourself from known harm.
Effective Care - you receive the right care and support as locally as possible and contribute to making that care successful.
Dignified Care - you are treated with dignity and respect and treat others the same.
Individual Care - you are treated as an individual with your own needs and responsibilities.
Our Staff - we have enough staff with the right knowledge and skills available at the right time to meet your need.

[1] Published by the Welsh Government on the 1st April 2015. For further information about the standards please use the following link: http://www.wales.nhs.uk/sitesplus/documents/1064/24729_Health%20Standards%20Framework_2015_E1.pdf

Introduction and Welcome

The purpose of our Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of the care that we provide. For more information about BCUHB Board Members, please find us on our website: www.bcu.wales.nhs.uk

Statement from Simon Dean, Interim Chief Executive and Mr Mark Polin, Chairman

Statement from Mrs Lucy Reid, Vice Chair / Independent Board Member and Mrs Gill Harris, Deputy Chief Executive / Executive Director of Nursing & Midwifery.

In Progress

North Wales Community Health Council

The North Wales Community Health Council (NWCHC) is the independent health watchdog for North Wales. It represents the interests of patients and the public who use BCUHB health services.

The NWCHC monitors and scrutinises BCUHB health services to improve the patient experiences; one of the many ways the NWCHC does this is by visiting health premises. All visits are undertaken by NWCHC volunteer members.

During 2019, NWCHC members visited all of our District General Hospitals and community hospitals, Emergency Departments and Mental Health Units. There have been in excess of 500 visits by NWCHC to our sites during this period when NWCHC members spoke to patients, their relatives and carers as well as staff about all aspects of health care experiences.

The NWCHC has focussed much of its work around BCUHB Mental Health Services. The NWCHC is concerned that this service remains to be under special measures with an apparent lack of progress against the recommendations made by the HASCAS and Ockenden reviews. Much of the feedback provided to the NWCHC during visits to various healthcare settings (including primary and community sites) has led to NWCHC having grave reservations about the unique I-CAN service model developed as a way forward for many aspects of providing mental health support. As such, the BCUHB Transforming Care team and other directorates continue to work collaboratively with the NWCHC and the NWCHC reports remain a part of the Ward Accreditation Programme.

To find out more about the work of the NWCHC, please contact:

- E-mail – admin@waleschc.org.uk
- Telephone – 01248 679284 (ext 3)
- Website – www.communityhealthcouncils.org.uk
- Write to – NWCHC, Unit 11, Chestnut Court, Parc Menai, Bangor LL57 4FH

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL
CIC GOGLEDD CYMRU / NORTH WALES CHC

Betsi Cadwaladr University Health Board (BCUHB)

The purpose of the Board is to govern the organisation effectively. We aim to build confidence in the quality and safety of care that we provide. For more information about Board members, please use the following link:
http://www.wales.nhs.uk/sitesplus/861/page/40836

This document forms part of our annual reporting. In addition to this report, our Annual Report and Annual Governance Statement can be found at the following link:

www.wales.nhs.uk/sitesplus/861/page/40903.

This report and supporting documents can be made available in other languages or formats on request from the Corporate Communications Team:

Email: bcuhbpressdesk@wales.nhs.uk

Telephone: 01248 384776

Address: Communications Team
Block 5
Carlton Court
St. Asaph Business Park
St. Asaph
LL17 0JG

There are many opportunities to get involved and share your ideas about how we can improve health in North Wales.

We are keen to hear from you, whether as a member of the public, patient or carer, or if you have a compliment or a suggestion.

It is your local health service.
Help us to help you!

You can also sign up to our involvement scheme. By registering, (please use the link below) you will get our newsletter, hear about how you can share your views and ideas and get updates on activities and events. We want to involve everyone irrespective of age, disability, gender, gender identity, race, religion or belief or sexual orientation.
http://www.bcugetinvolved.wales/register

In Progress

About BCUHB

BETSI CADWALADR UHB

POPULATION

698,400 persons

North Wales has an increasing and ageing population. The population is expected to increase to 734,700 by 2036; the percentage of the population aged 85 years and over is expected to increase by 154% between 2011 and 2036.

LIFE EXPECTANCY

BCUHB

82.4 YEARS — 78.9 YEARS

The difference in life expectancy between the most and least deprived is 7.4 years for men and 6.1 years for women. In Wales, there has been a plateauing in increasing life expectancy since 2011.

OLDER PEOPLE

15% of households in BCUHB are occupied by one person aged 65 years and over, which is just above the average for Wales (14%). Conwy has the highest percentage of one person households with people aged 65 years and over (17%).

Isle of Anglesey, Gwynedd and Denbighshire are also higher than the BCUHB average.

Flu immunisation uptake in 65 year olds and over in

FALLS

1 in 3 older people will suffer a fall each year. Only 1 in 3 will return to former levels of independence and 1 in 3 will end up moving into long term care.

Yet many falls are preventable.

CHILDREN & YOUNG PEOPLE

Almost a quarter of children and young people under the age of 20 years live in poverty in Wales. Across BCUHB, this ranges from 18% in Gwynedd to 25% in Denbighshire.

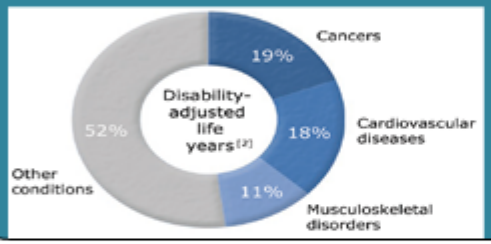
70% of 5 year olds in BCUHB are of healthy weight compared to 74% in Wales.

88% of 4 year olds in BCUHB are up to date with vaccinations. This ranges from 84% in Denbighshire to 90% on the Isle of Anglesey.

BURDEN OF DISEASE

This chart shows the greatest cause of Disease burden in Wales, as measured by Disability Adjusted Life Years (DALY).

'Other conditions' includes mental & substance use disorders, other non-communicable diseases and neurological disorders.



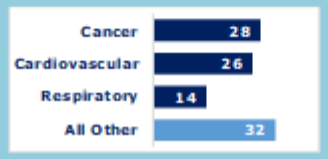
DEPRIVATION

Around 12% of the population of BCUHB live in the most deprived fifth in Wales. The Health Board has some of the most deprived areas in Wales, particularly along the North Wales coastline.

MAIN CAUSES OF MORTALITY

Heart disease, cancer and respiratory disease are the leading cause of death in BCUHB.

This chart shows the main causes of death as a percentage of all deaths in BCUHB



CANCER

4 in 10 cancers are preventable.

MENTAL WELLBEING

16% of people in BCUHB report feeling lonely which is lower than Wales (17%). Across the Health Board, this ranges from 13% in Flintshire to 20% in Wrexham. 83% of people in BCUHB report having a high sense of life satisfaction compared to 81% across Wales.

BEHAVIOURS AFFECTING HEALTH

	BCUHB (%)	Wales (%)
Smoking	18	18
Use e-cigarettes	7	6
Drinking above guidelines	18	18
Physical activity	55	53
Fruit & vegetable consumption	23	24
Overweight/obese	54	60
Follow 0/1 healthy behaviours	10	10

Looking Back Over the Past Year

We have made significant progress against the priorities outlined in our **Quality Improvement Strategy 2017-2020**. The key priorities include reducing avoidable deaths, reducing harm and providing reliable care by strengthening our patient care pathways through our services and delivering what matters to patients accessing our services. Among the key things we have done to support these improvements are:

- The Maternity Dashboard has been introduced and captures BCUHB compliance against national standards for maternity care in Wales. The Inpatient and Community Dashboards are populated and reviewed monthly at the Women's Quality, Safety & Experience Sub Group and Women's Board meetings. For assurance, where themes or trends are identified, the meeting Chair may request an audit or thematic review is performed and presented at a future date for further information

- Using crude mortality as an indicator, we can identify any variation from normal and initiate investigation at case-note level to ascertain lessons to be learned. The Emergency Department at Ysbyty Glan Clwyd now have a process in place to review all deaths within 5 days and to capture lessons learned. Reviews now have a structured judgement approach (SJR hybrid) and are tracked on our information Reporting Intelligence System (IRIS).

- In November 2018, we introduced our Ward Accreditation programme which assesses wards and units across the region on a range of quality measures. As of January 2020, there have been 90 unannounced visits / Ward Accreditations to wards. These 90 accreditations include Acute, Community, Childrens, Critical Care, Women's and Mental Health & Learning Disabilities.

- Over the 3 years of the strategy, we recorded 17 Never Events compared to 15 in the three years prior. This is well within common cause variation and as such, there has been no change in the overall rate of Never Events. For assurance, a thematic review will take place and our next QIS strategy will ensure that there is a greater focus on patient safety.

- We have seen a decrease in clostridium difficile and MRSA blood stream infections over the past 3 years. The Infection Prevention & Control team have commenced several new initiatives during 2019, which will assist with trends and the ability to prioritise risks to the population, and increase screening.

Looking ahead, the aim is to complete a review of progress against the Quality Improvement Strategy and plan for the next three years by engaging with our patients, staff, partners and our communities. We will also reshape our Quality Improvement Strategy by January 2021.

Your Feedback

The Patient and Service User Experience team has collected 22,247 real-time survey responses from patients, cares and relatives across North Wales, about their experiences of using our services within 2019. In addition to providing feedback in relation to the all Wales NHS Patient Related Experience Measures, the survey asks service users to share their opinions about:

- 'What was good about your experience?'
- 'Was there anything that could be improved' and
- 'Promoting Equality in everything we do'

Feedback provided from Patients and Service users provide us with the vital information on how we are doing which enable us to share what is working and make improvements where necessary. Overall, the feedback told us that our services contribute to a positive experience, with an overall satisfaction rating of 8.97/10. In addition to real time feedback, the Patient and Service User Experience Team received 2,201 comment cards, emails, letters, responses and feedback received by our Patient Advice Liaison and Support (PALS) officers.

Your feedback is extremely important to us and is used to focus service improvement efforts. We continue to aim to develop patient and service user feedback in order to listen to the voice of all of our patients in all of our care settings, from the very young to the older person. Feedback from patients and service users will continue to be the most valuable source of information which helps inform the development of services.'

2019 saw the launch of PALS officers in Ysbyty Gwynedd and Ysbyty Maelor Wrexham following a successful pilot of the PALS service in Ysbyty Glan Clwyd. All three localities have three PALS officers based in accessible hubs located in each main entrance of the hospitals and two Patient Experience Co-ordinators. Following the launch of the PALS hubs we have seen a significant increase of patient liaison due to the prime locations and have formed / strengthened good working relationship with our colleague's.

How we have measured our performance

	Improved performance	Sustained performance	Decline in performance	Target Summary	Target Achieved
STAYING HEALTHY - I am well informed & supported to manage my own physical & mental health	2 measures	0 measures	1 measures	↑	
SAFE CARE - I am protected from harm & protect myself from known harm	11 measures	1 measure	3 measures	↑	6 measures
EFFECTIVE CARE - I receive the right care & support as locally as possible & I contribute to making that care successful	6 measures	0 measures	1 measures	↑	2 measures
DIGNIFIED CARE - I am treated with dignity & respect & treat others the same	1 measure	0 measures	2 measures	↓	
TIMELY CARE - I have timely access to services based on clinical need & am actively involved in decisions about my care	11 measures	1 measure	11 measures	↔	5 measures
INDIVIDUAL CARE - I am treated as an individual, with my own needs & responsibilities	2 measures	0 measures	3 measures	↓	2 measures
OUR STAFF & RESOURCES - I can find information about how the NHS is open & transparent on use of resources & I can make careful use of them	8 measures	0 measures	3 measures	↑	3 measures
SUMMARY	**41 measures**	**2 measures**	**24 measures**	↓	**18 measures**

Our performance is measured across seven key domains or areas, aligned to the Welsh Government's Health Care Standards and National Performance Frameworks.

The summary dashboard (left) shows our performance across the range of indicators the Welsh Government uses to measure all Health Boards in Wales **(link).**

We have demonstrated overall improvement in relation to helping people to stay healthy and in delivering dignified and individual care. However our performance has declined in respect of delivering timely care and when measured against the indicators for safe and effective care.

Each month we provide detailed briefings to our Board on our performance, outlining the Key Actions being taken to address poor performance, what the Outcomes of those Actions are and the Timeline for when we expect performance to consistently achieve the target.

For 2019/20, we have only included the nationally mandated Measures in our reporting to reflect the priorities of the organisation and improve the health, care and experience of the North Wales population.

Progress against our strategic priorities

Improving Health and Reducing Health Inequalities	Care Closer to Home	Excellent Hospital Care
• Healthy Weight: We have developed the Tier 2 (Adult) Obesity service • We continue to review and identify opportunities for improving access to children's weight management services • Smoking Cessation: We have increased opportunities through stabilising the Help me Quit in Hospital • Wellbeing: We have developed the 'I Can' campaign and 'Let's get moving North Wales' partnerships • We have progressed our partnership plan for Children • We continue to improve our outcomes through 'First 1000 days' programmes • Immunisation: We have developed the Health Board's first Strategic Immunisations Plan which outlines how we will optimise uptake of key vaccinations across the life course, with a specific focus on Flu and MMR • Reducing Health Inequalities: We are progressing our work on reducing health inequalities – we have worked with partners to develop initiatives which target food poverty, housing and homelessness	• Healthcare Support Workers (HCSW) at Ysbyty Alltwen are leading a project which aims to prevent delays for patients leaving hospital by offering support for those, who are ready to leave hospital but may be waiting for a care package, in their own home. • A pilot scheme to help patients get fit for major surgery in order to reduce the risk of complications following their operations has been introduced at Wrexham Maelor Hospital • Community NHS staff are ramping up sepsis monitoring as part of Wales-wide improvement programme. New equipment is helping district nursing staff identify sepsis. • Wrexham Maelor Hospital is the first in Wales to offer same day discharge hip replacement surgery, some patients are able to go home on the same day due to surgeons using a new method of delivering post-operative care • Specialist teams of Occupational Therapists are helping Glan Clwyd patients get ready for returning home following a pilot study, which reduced length of stays by almost 50 per cent	• Doctors in training have ranked Ysbyty Gwynedd's Emergency Department as one of the best places to train in the UK. Results from the recent National Training Survey by the General Medical Council shows over 85% of doctors in training are pleased with the quality of clinical supervision, experience, and the teaching they receive at the Emergency Department. • A new system designed to speed up diagnosis for people with suspected cancer has been introduced in North Wales. We have issued guidance to GPs to help them determine whether patients with symptoms of colorectal cancer can be referred directly for an investigation, bypassing an outpatient appointment and saving time. • People living with dementia and their carers have joined health experts in praising the 'first class' memory support provided across North West Wales. The Gwynedd and Môn Memory Service has been given a top quality mark by the Royal College of Psychiatrists for the third successive time for providing the highest standards of care for people living with dementia and other memory problems.

Staying Healthy

• We have developed integrated multiagency Health & Wellbeing Centres		

Smoking

In October 2019, the management oversight for smoking cessation services was transferred from Public Health Wales to BCUHB, which creates an opportunity to review service provision across the four teams that deliver smoking cessation services. This provides opportunity to review the service offered and maximise reach.

Respiratory Health Project

20% of the population of Blaenau Ffestiniog have been identified as being smokers. This, combined with the legacy of the slate mining industry has contributed to poor respiratory health and 11% of those patients registered at the GP practice (Canolfan Goffa Ffestiniog) were identified as suffering from chronic respiratory conditions.

The practice were identified as one of the highest prescribers of inhaled corticosteroids within the health board, which prompted the cluster to identify ways to develop more effective strategies and treatments to improve respiratory health.

Steffan John, an independent pharmacist prescriber specialising in respiratory health conducted 6 sessions which included:

- Identification of patients and inviting patients to respiratory clinics
- Education and training of healthcare professionals in COPD diagnosis and management
- Review and improve inhaler techniques

Protecting people against Flu

Protecting people against the risk of flu is a major element in helping the NHS reduce the demand for emergency care over the winter period. The number of people eligible to be vaccinated and receiving vaccinations has increased year on year in both the under 65 and over 65 age groups. The increased volume of vaccinations given demonstrates the hard work our staff have done to promote the need for vaccination. As a result, by 31st March 2020, over ## more people in North Wales had been vaccinated compared to the year before.

The national target is for 75% of the eligible groups (people aged over 65, and those aged below 65 who are at greater risk from infection) to be vaccinated. North Wales had the highest take up rate in Wales, at ##% for those over 65 and ##% for those under 65. This is an improvement for the over 65 age group. However, the increased number of people aged under 65 who were eligible to be vaccinated last year meant that the take up rate fell, even though the number of people in this group who were immunised increased. This shows that we need to continue our efforts to encourage people to protect themselves.

Prevention

Three Year Strategic Immunisation Plan 2019-2022

Betsi Cadwaladr University through the development of its three year Strategic Immunisation Plan (2019-22), has committed to protecting and improving the health of the population through maximising uptake of vaccines for eligible groups across the life course.

This will be achieved by focussing on reducing variation in uptake, sharing learning and further embedding a culture of quality improvement, strengthening governance arrangements, improving how we communicate and engage key stakeholders and taking every opportunity to immunise our public, patients and staff. The Health Board's improvement priorities are shown below.

A range of routine vaccinations programmes are being delivered across North Wales by BCUHB and primary care contractors. Further selective, medical, occupational and travel immunisations are also provided, including influenza vaccinations for pregnant women and people with chronic conditions; Tuberculosis, Hepatitis B and influenza vaccinations for staff involved with direct patient care; and travel vaccines for people travelling to certain countries.

Childhood Immunisation

BCUHB has historically performed better than the national average for uptake of most childhood immunisations, although there is variation based on geographical area and uptake rates decline from infancy through to later childhood.
In 2018/19, 89.7% of resident children in North Wales were up-to-date with scheduled vaccines on reaching their fourth birthday. This is higher than the other health board areas and Wales. However, uptake in the least disadvantaged areas in BCUHB is generally much higher than in the most disadvantaged areas and so there is an inequity. We have appointed a further two immunisation co-ordinators who are targeting the areas most in need.

Measles, Mumps and Rubella (MMR)

Uptake of the first dose MMR vaccine in children aged two years in BCUHB was just above the 95% target in 2018/19.The highest uptake was in Isle of Anglesey. MMR uptake at age five years in BCUHB was just below the 95% target in 2018/19. However, Isle of Anglesey, Flintshire and Wrexham all reached the target. We continue to work with our communities to promote immunisation and dispel myths.

Healthy Weight Services

BCUHB continue to progress towards establishing a tier 2 service with the inclusion of a commercial weight provider as part of the package of service options. The Kind eating and Foodwise programs have expanded during 2019/20 with an increase in patient contacts.

We have been scoping models of good practice and performance to develop our tier 3 children's obesity service during 20/21. This work will contribute to the delivery of 'Healthy Weight: Healthy Wales' long term strategy to reduce and prevent obesity.

During 2019, our Infant Feeding Strategy was launched The vision is to create a supportive culture in North Wales that enables parents to make the choice about infant feeding in an informed way that optimises nutrition and helps develop close, loving relationships with their baby.
Giving every child the best start in life is crucial to reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid down in early childhood.

Let's Get Moving North Wales collaboration continues to work together to improve the health and wellbeing of the population of North Wales, through increasing opportunities to be more active.

Winter Wellness Campaign

Our East Area Team's Winter Wellness Campaign was a public facing awareness raising campaign provided to offer advice and support to members of the community on the importance of keeping well particularly through winter. The campaign covered five themes which include: Skin Care, Hydration, Falls Prevention, Choose Pharmacy and Flu Vaccination and Supporting Carers. Initially, a week of Roadshow events were held in Wrexham and Flintshire. Subsequently members of the team have been promoting the campaign in Food Festivals and Bite Size Health in the Workplace events.

Children's Outpatients; Free Fruit

BCUHB catering, dietetics and paediatric department alongside the Awyr Las charity collaborated in 2019 to trial offering free fruit to children in the paediatric outpatients area. The trial initially ran within the Wrexham Maelor paediatric outpatients but has since rolled out to the other main hospital sites. On average 40-60 pieces of fruit are being delivered four times a week with no wastage reported. The reception area actively promotes the offer with colourful posters and fruit themed activities for the children, such as colouring and word searches. Parental feedback has been so positive and the offer has continued with the support of the catering team.

Young People for Young People

Hannah Mart, Children and Young Person's Sexual Violence Adviser, based at the Amethyst Sexual Assault Referral Centre has been working with a group of young people to develop a resource booklet entitled 'Sharing Stores / Rhannu Straeon'. The aim of the resource was to provide information and advice to other young people about and the criminal justice process and how to cope with it, to support their recovery, reduce their isolation and increase their resilience. In addition, it can be used to help professionals to understand the experience of the CJS journey from the perspective of the survivor and better support them.

The project developed momentum and in addition to the booklet a film and podcast was developed. The 'Sharing Stores / Rhannu Straeon' film and podcast was launched officially in September 2019. The project was submitted as an application to the Problem Orientated Police Awards (POP). Hannah and some of the young people involved were invited to the Awards ceremony to present the project, although it didn't win the judges were so impressed with the work they decided to award the judges discretionary fund of £3000 to the project.

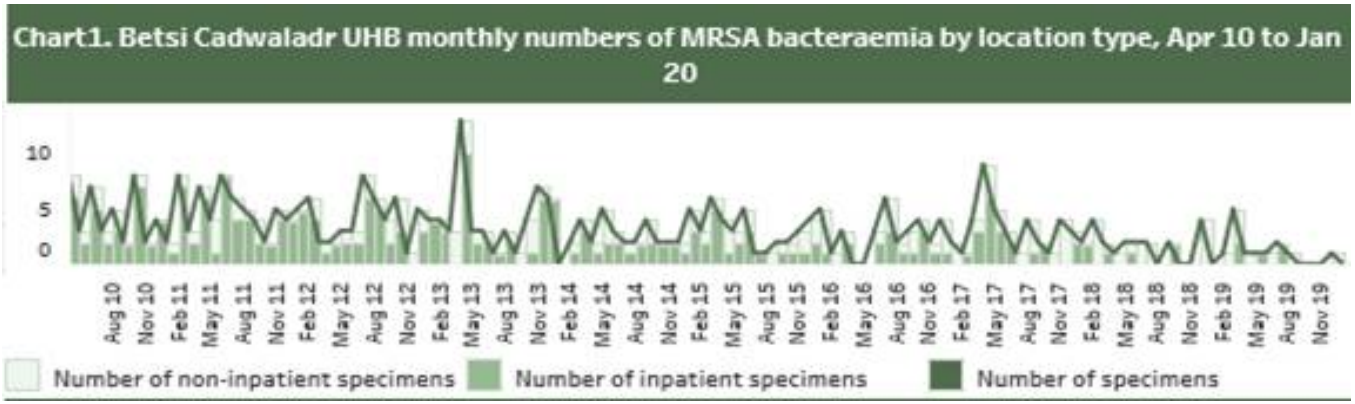
Safe Care

Safe, Clean Care

There has been continued focused improvement and reactive work relating to infection prevention, as well as the inclusion of the Safe Clean Care campaign for the past year. This includes reducing unwarranted variation, developing a link practitioner programme, with our first in house educational event.

Janice Stevens revisited the Health Board and gave a positive report back to the Executive team on progress in the last year. In addition internal audit revisited and assurance levels overall were increased from the previous year in relation to Safe Clean Care and Infection Prevention & Control. A snap shot audit on urinary catheters took place in September 2019 and preliminary results suggest less than 2% of those patients had an infection associated with urinary devices. This is alongside the achievements to date in reduction of Meticillin Resistant Staphylococcus Aureus blood stream infections which has decreased by a further 46% to date compared to 2018/19, from 2.72per 100K population to 1.20.

However, we recognise there are still particular infections to concentrate on, such as gram-negative bacteraemia and collaborative work programmes in primary and community care with other specialist services.



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SAFE CLEAN CARE

Focus on Quality Improvement

The Health Board introduced a programme of focused improvement work that includes the Ward Accreditation Programme, which commenced mid October 2018, quickly followed by the Hospital Acquired Pressure Ulcer Collaborative (HAPU) in late November 2018 and then the Inpatient Falls Collaborative in June 2019.

All key programmes of focused improvements provide an opportunity for the Health Board to embed the principles of a common Quality Improvement language and methodology as well as embedding a set of standards to frame our quality, safety and patient care agenda and to maintain the momentum of the improvements and principles of the Safe Clean Care campaign (SCC).

A collaborative approach to reducing harm

By using a collaborative approach, we have focused improvements relating to our key harms (Inpatient Falls and Hospital Acquired Pressure Ulcers). The collaborative is a small number of identified wards who have come together with support from Quality Improvement team & subject experts as a faculty through a planned sessions face to face and virtually has led the embedding of a common language and understanding of quality improvement for all levels of ward staff. It has helped us identify standards for all our the wards to follow in terms of identifying and reducing harm from Hospital Acquired Pressure Ulcers and then for Inpatient falls once collaborative completed.

Outcomes to date include standardise reporting of incidents, streamlining and easy access to educational resources, development of chair awareness audit engaging visitors and the public in reducing harm from falls.

Falls: DATIX reporting SBAR

S	**Situation:** What is the immediate situation? • Identify self, unit, patient & room number. • Briefly state the problem.
B	**Background:** What led to this situation? • Admitting diagnosis and date of admission. • Current medications, allergies & IV fluids. • Brief history. • Current treatment.
A	**Assessment:** What do you think the problem is? • Explain your assessment of the patient and how you came to this assessment e.g. stable or deteriorating.
R	**Recommendation / Request:** What do you recommend should happen next? • Review / see the patient now. • Perform / review tests. • Reassess / consider: o Foot wear; o Location of patient on ward; o Mobility aids; o Falls Pathway; o Inform family and members of MDT; o Visual cues. • Complete the post falls checklist / documentation.

Ward Accreditation

Launched in November 2018, our Ward Accreditation programme assesses wards and units across the region on a range of quality measures. Wards which demonstrate excellent care are awarded a bronze, silver or gold award following an in depth assessment by nursing leaders.

Work of the Ward Accreditation programme continues with all wards having received an unannounced visit. To date 95 wards have been visited of which one has received a Gold ward. The programme will continue and is fully embedded within the Health Board as a way of supporting our teams with implementing a set of standards, sharing improvements and celebrating success.

Gold Award

Staff on Hydref Ward at the hospital's Heddfan Psychiatric Unit have been awarded Betsi Cadwaladr University Health Board's Gold Accreditation for providing the highest standards of care. Hydref Ward is the first in North Wales to be awarded the gold accreditation. The ward provides support for older adults living with a range of mental health conditions, including bipolar disorder, severe depression, personality disorders and schizophrenia

Psychiatric Intensive Care Unit staff named Nursing Times' Team of the Year

Our Wrexham based Psychiatric Intensive Care Unit staff were named the Nursing Times' Team of the Year for their work to bring laughter and joy to people most seriously affected by mental ill health. Staff from Tryweryn Ward at Wrexham Maelor Hospital's Heddfan Unit beat stiff competition from NHS teams from across the UK.

The prestigious award has been given in recognition of "incredible" changes the team have made to the eight-bed Tryweryn Pychiatric Intensive Care Ward, which provides care and support for people who are so acutely unwell that they cannot be safely treated on a general mental health ward. This has seen the introduction of a of a range of new activities and therapies on the ward, including joint yoga sessions, hand massages and baking, as well as a new 'rant and relax room', which has been designed by patients.

Caniad Service Manager Denise Charles said: "Different people let off steam in different ways. If someone is feeling like they're not able to express themselves, they may become very distressed. Instead of needing to safely restrain them, we can guide people towards the safe room and encourage them to either let it all out, or just lay under the weighted blanket. We comfort them".

"Since introducing the changes, Tryweryn Ward staff have managed to halve the number of restraints performed, while patient satisfaction scores have increased significantly in the same time. "There is now much more laughter on the ward because it's patient-led".

Ward Manager Matt Jarvis said: "It's all very simple really – just asking how we can support people's individual needs, and actually listening to what they have to say".

Mortality Reviews, mortality data, serious incidents, never events, safeguarding

In Progress

Effective Care

You receive the right care and support as locally as possible and contribute to making that care successful

Emergency Department Pathway Redesign for Management of Specific Fractures

The purpose of the Emergency Department (ED) Direct Discharge for the East area, was to redesign the pathway of care for the management of six specific fractures and injuries. All patients with acute fractures have traditionally been referred to a fracture clinic soon after injury. However, many simple stable fractures and injuries can be discharged from the ED with standardised advice leaflets, access to telephone advice and no further follow up in fracture clinic.

- Implementation commenced on the 1st Oct 2018 and data was collected prospectively for 12-months. Patients diagnosed with one of the six specific injuries were put onto the 'Self Care Pathway' (SCP) receiving the appropriate treatment and an advice leaflet, prior to being discharged from the ED.

- The ED physiotherapist collated patients put onto the SCP, reviewed the notes/X T Rays with an Orthopaedic Consultant on a weekly basis, to ensure patients' were safely, and appropriately discharged from the ED. Patients either remained on the SCP, were referred to Occupational Therapy (OT) for onward management (mallet injuries only) or were recalled to attend fracture clinic. At 8 weeks post injury, the ED physiotherapy practitioner carried out a telephone review for patients who remained on the SCP without any routine follow up. Additionally, the ED software system was used to examine how many patients were referred to fracture clinic with one of the 'six' injuries, rather than being treated on the SCP:

- 255 (67%) out of a possible 378 patients were put onto the SCP, with 231 (91%) remaining on the SCP after the orthopaedic review. Only 2 (1%) patients who were accurately put on the SCP, re-attended the ED with ongoing pain/disability and were subsequently seen by an orthopaedic consultant and fracture clinic respectively. Of 62 patients contacted on the telephone review, 98% reported normal function and near/full recovery from their injury. 231 fracture clinic appointments were not needed.

This work has improved the pathway of care without compromising the overall outcome and subsequently, less travel time and time off work for the patients' to attend an appointment and fewer fracture clinic appointments, thus reducing the workload of the fracture clinic.

Wrexham Maelor Hospital Annual Symposium: Quality Improvement (QI) and Audits

This was the second “Annual QI-Audit symposium” at Wrexham Maelor, which was attended by 94 staff members from various disciplines. It included 10 selected QI projects/audits presented by medical and nursing staff and was very well received by all attendees with excellent feedback. Three prizes were awarded for the best projects and the first prize was won by the orthopaedics team for their brilliant results with “Personalised total hip replacement pathway” at Maelor. Quotes from attendees included:

- “Excellent. A wide range of subjects and inspirational for innovative change”.
- “Good practice to carry forward. Very informative and current, pro-active projects, very encouraging and a pleasure to hear”.
- “A variety of projects from various specialities! Wonderful presentations given throughout. Good quality projects! Excellent-excellent!”.

‘One Stop Shop’ – Shoulder Clinic

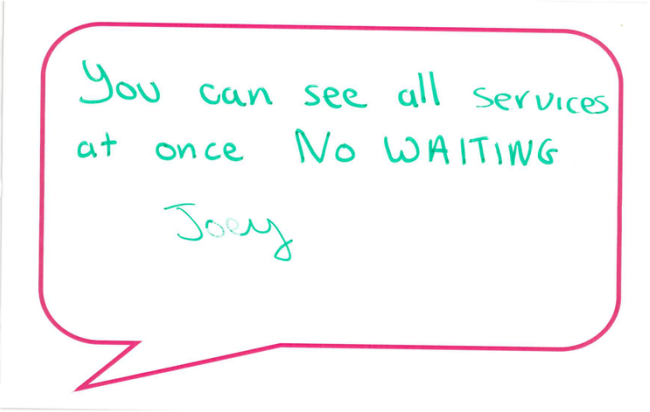
Implementation of the ‘One Stop Shop Shoulder Clinic’ started on 1st April, 2019. The purpose of implementing a ‘One Stop Shop’ shoulder clinic within the musculoskeletal triage service (CMATS) was to improve the pathway of care for patients with shoulder conditions. This service enables patients to attend one appointment and receive a musculoskeletal assessment with immediate access to diagnostic ultrasound scanning and injection if indicated.

“Everything! One-stop service. Excellent consultation. Explained what was wrong with me – able to have tests, exam and ultrasound all in one visit. Brilliant! Can't fault”.

- Between April 2018 and August 2019, 131 patients were seen in the one stop shoulder clinic. Following clinical assessment, 61% of these patients proceeded to ultrasound scan, 39% of patients did not require a scan.
- There were 142 GP referrals for shoulder ultrasound to the radiology department. There has been a 44% reduction in shoulder ultrasound activity when compared scans performed between April 2019 and August 2019.
- The average waiting time for ultrasound within the radiology department between April 2018 and August 2018 was 9.4 weeks. The average waiting time between April 2019 and August 2019 was 6.1 weeks. This demonstrates a 35% reduction in patient waiting times during April 2019 and August 2019.

Community Care Hub

The Community Care Hub is led by Dr Karen Sankey and Dr Dewi Richards and was established in the Salvation Army, Wrecsam in January 2017. Dr Sankey has been a GP for 25 years, but she feels modern general practice is "not fit for purpose", particularly for vulnerable groups, who tend to "just fall through the cracks".



The Community Care Collaborative Hub provides a one-stop shop for every service that people may need. It's a drop-in session which happens every Friday bringing together 29 agencies. The 'Everyone in the Room' model brings together all the agencies that people need in the same room, at the same time every week. This system means people do not have to worry about missing appointments or needing paperwork they don't have access to. On average it supports 60 people each week who are homeless, sleeping rough or have mental health or substance misuse problems. In the last financial year, 850 people accessed its services. The PALS have been working alongside the other 28 agencies since September 2019.

Dignified Care

You are treated with dignity and respect and treat others the same

A peaceful setting

In early 2019 we introduced a new care suite at Wrexham Maelor Hospital which will provide a peaceful setting for people with dementia to spend their final days. The facility at the hospital's Heddfan Older Persons Mental Health Unit will ensure that people with dementia can receive end of life care in a dignified setting away from the main hospital environment, if this is their wish and that of their family.

The refurbished suite, which will support patients on Gwanwyn Ward, has dedicated facilities to enable families to stay close to their loved one and follows our commitment to John's Campaign, which advocates for carers' right to stay. It forms part of our efforts to improve the quality of Older Person's Mental Health services and act on the recommendations of external reports by the Health and Social Care Advisory Service and health investigator Donna Ockenden.

"People with dementia have as much right as any other person to a dignified death with an assurance of compassionate and high quality care. As a health board, we recognise the need for preferences and decisions about end of life care to be identified as early as possible and we advocate for people to be able to have these conversations when they feel the time is right. As such we are supporting our staff to have the knowledge and skills that are needed." Sean Page, Consultant Dementia Nurse at BCUHB

"It Makes Sense"

On November 28th 2019, the fifth hosting of the All Wales Sensory loss conference that precedes the "It Makes Sense" annual campaign took place. The purpose is to highlight provision of care, service and support for the sensory loss community and shine the spotlight on those who provide vital support. The event this year was hosted by Betsi Cadwaladr University Health Board and organised by the Patient and Service User Experience Team.

The event was compromised of guest speakers and presenters to showcase their specific sensory loss organisation or supporting elements, there were updates of developing awareness of sensory loss groups, supporting mechanisms and roles specific organisations have with providing such things as accessible Health care, patient support, carers and relative support and training. The event also provided workshops to aid in the understanding of sensory loss across the spectrum of sight loss, blind, visually impaired, deaf, hearing loss and the mental health of those who have a sensory loss.

- The event was also planned as a unique networking meeting for delegates, health care professionals and the sensory loss community to come together under one roof for the purpose of sharing, supporting and highlighting changes, updates or new innovation for sensory loss.

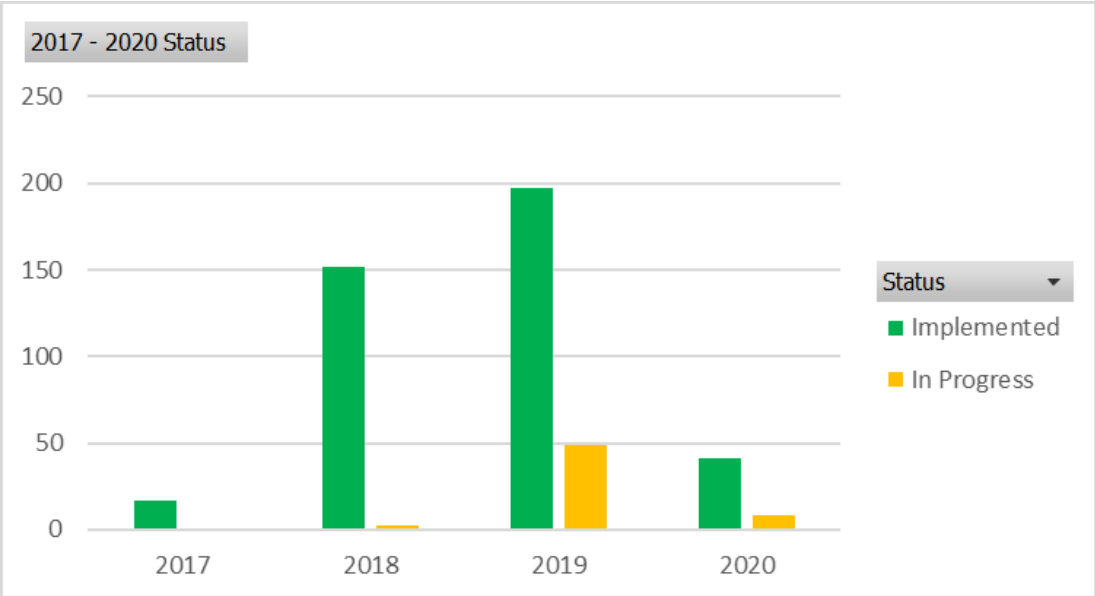
- The event attracted over 140 delegates from all over Wales and England who had an interest in sensory loss ranging from service users to Ophthalmic consultants and University students, supporting organisations, National Charities and regional and local third sector groups who provide for specific sensory loss communities within their areas.

Health Care Inspectorate Wales

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales. Their purpose is to check that people in Wales receive good quality healthcare.

The Health & Care Standards help us to provide a delivery of high quality services in the NHS in Wales. These standards were developed by Welsh Government in line with the NHS Outcomes and Delivery Framework through a broad range of consultation with stakeholders. Healthcare Inspectorate Wales assess healthcare provision against these standards. Each inspection considers how the service meet the Health and Care Standards under three domains: the quality of the patient experience; the delivery of safe and effective care; and the quality of management and leadership.

The Health Board has in place a process for managing HIW inspections, concerns and enquiries with a tested the assurance methodology, which provides opportunity for rigorous and meaningful action planning and tracking. In addition, it provides assurance through our governance reporting structure up to the Health Board's Quality, Safety and Experience Committee for scrutiny and oversight.



As shown (left), each year the Health Board has improved the progress we make with ensuring that any actions agreed following HIW inspections and recommendations are implemented in line with the Health and Care Standards.

In addition, work has been undertaken to ensure that there is sufficient assurance for each action, prior to closure through monthly reporting to the Health Boards Quality and Safety Group, which is chaired by the Executive Director of Nursing.

As a Health Board, we appreciate the work of Healthcare Inspectorate Wales as it enables us as an organisation to strengthen and improve the services we provide. As such, we welcome further opportunities to work closely together to provide assurance and to make a difference for our service users and residents.

Timely Care

Advanced Paramedic Practitioner Project

Advanced Practice Paramedics provide a rapid response service to patients requiring home visits, which would previously have been provided by their GP. The purpose of this project is to support GP practices in North Wales to improve the quality of care, transform the way that care is delivered in the community, and help sustain Primary Care services by reducing emergency admissions, improving patient access, releasing capacity for GPs to focus on planned care appointments in their Practices.

The scheme will support Primary Care sustainability, improve patient access, and deliver more services in the community.

Unscheduled Care

Flow in our services: The Same Day Emergency Care in Ysbyty Glan Clwyd commenced on 3rd July 2019. This has been developed as an ambulatory emergency unit that will see, treat and discharge patients on the same day, many of whom would previously have stayed in hospital for several days and reduce non-admitted breaches and admissions and help to prevent overcrowding in ED.

Wrexham Maelor Hospital have reconfigured their Emergency Floor area to provide assessment space, including ambulatory emergency care and a frailty unit. The new space was opened on 4th November 2019 with the aim of reducing the number of patients waiting over 12 hour in ED, reducing admissions and reducing the length of stay across the Hospital.

SAFER principles (Senior review; All patients; Flow; Early discharge; Review) continue to be embedded across the sites and the number of patients with delayed transfers of care continues to improve with a focus on stranded patient reviews developing a specific focus on patients over 21 days in both Acute and Community Hospitals. This involves Local Authority, Area Colleagues and Hospital staff for more collaborative working in providing better care for patients and in the right setting. A standard operating procedure for SAFER has been developed to clearly define how this can be used to support patient flow, patient experience and keep our patients safe.

Discharge from our hospital services: Placemats were trialled in wards in community and acute sites across BCUHB with the prompt for patients to ask questions about the reason for their admission, what is happening to them today and planning for their discharge and this concept has been adopted by the Delivery Unit across Wales. It is key that we engage our patients and carers in all aspects of their care (What Matters) and understand their needs from the time of their admission, to support early safe discharge.

We are working closely with the Welsh Ambulance Service to develop our longer-term service model for call handling and triage. The SICAT (Single Integrated Clinical Assessment & Triage) service continues to develop. Our ambition is to work with all our partners and our public as part of our emerging services strategy to strengthen these so patients can receive the best care as close to home as possible. Planning work is underway to build this into the 111 service. We have secured recent funding to pilot an expansion of this service to support patients in nursing and residential homes in the East area to prevent hospital admissions.

Reducing Risk and Harm

Examples of actions taken to reduce risk of harm associated with delays in accessing services/care, including participation in the national planned care programme.

In Progress

Treating People as Individuals

Improving services for vulnerable groups

In 2019, a Wrexham based health visitor was named the winner of the Advancing Equality Award at a glittering gala evening at Venue Cymru to mark the Betsi Cadwaladr University Health Board Achievement Award 2019. The awards, sponsored by Centerprise International, celebrate the outstanding achievements of NHS staff from across North Wales.

Jackie has been recognised for what colleagues describe as an 'inspirational' commitment to providing health and wellbeing support to asylum seekers and refugees from Syria and other war torn countries. Since 2001 Jackie has supported the resettlement of hundreds of asylum seekers, trafficked women and refugees in the Wrexham area. Wrexham is one of four dispersal areas in Wales and the only area in North Wales which receives asylum seekers from the Initial Assessment Unit based in Cardiff. On arrival in Wrexham, Jackie coordinates their health and wellbeing assessments and provides ongoing support to ensure that asylum seekers can access a range of health services. She also runs drop in sessions which bring a range of support services together under one roof.

Support for individuals with Learning Disabilities

There are specialist learning Disability Acute Liaison Nurses (ALNs) covering the 3 District General Hospital's, within office hours, in BCUHB. They provide support to individuals with learning disabilities, their families and carers when they are accessing mainstream hospital services. This service was introduced as a result of a plethora of evidence which highlighted that having a Learning Disability means that hospital services are not always aware of how to meet the care needs. This can result in delays in treatment, and worse case scenario, lead to premature, avoidable deaths (Confidential Inquiry into premature deaths of people with Learning Disabilities 2013, Death By Indifference MENCAP 2010) The ALNs also provide education and training to hospital staff at all levels, and have also trained around 120 Learning Disability Champions with plans to continue to recruit more.

BCUHB also has a Patient Contact Notification system. This e-mails the ALNs when a person who is known to have a Learning Disability is admitted. This ensures that the person is identified as having a learning disability early in their admission to hospital. There are also Learning Disability Primary Liaison Nurses and skilled Health Care Support workers in the community. Their role is to improve access for individuals with a Learning Disability to mainstream primary care services and to improve the uptake of the annual health checks by working with service users, carers and families as well as services.

Supporting Welsh Speakers

The Health Board's Language Choice Scheme has been greatly expanded during the past year and is now in operation on wards within all three BCUHB acute hospitals and at numerous community hospitals. Orange magnets – adorned with the instantly recognizable orange 'Working Welsh' logo – are placed on bedside white boards (and also on staffing boards), in order to identify Welsh speakers and facilitate the process of pairing patients and staff who can speak the language.

Welsh language training has developed to be an integral part of developing Welsh language skills of BCUHB staff. Our comprehensive programme has attracted funding of over £200,000 a year from Gymraeg Gwaith/Work Welsh, a scheme funded by Welsh Government, which also includes funding to employ a Welsh Language Training Support officer for BCUBH since April 2018. Since being part of the Cymraeg Gwaith / Work Welsh scheme in April 2018, 9.4% of the workforce have registered, completed and received Welsh language training.

As well as the work welsh initiative our BCUHB Welsh Language Tutor offers courses tailored to the needs of BCUHB staff members - on a language level, and to the type of work they undertake from day to day, allowing staff members to gain the relevant Welsh language skills in order to offer a bilingual service and therefore meet the needs of their patients

Our staff

Challenges recruiting and retaining our staff

As at January 2020, BCUHB employed 18178 staff of which 15594 are full time equivalent (FTE). However, recruiting and retaining key staff remains a challenge. This is reflected in our vacancy rates.

At present the Health Board has a 9.1% overall vacancy rate.

Nursing and Midwifery

- Vacancy rate of 11.3%, which has been reducing in recent months. However, this has been helped by the recruitment of 50 FTE Nursing and Midwifery staff in the final quarter of 2019
- Across 2019, overall growth in the Nursing and Midwifery workforce was just 18.5 FTEs whilst the budget increased by 67 FTEs. This demonstrates the struggle for recruitment to keep pace with increased demand
- A similar picture is presented at a national level where Nursing and Midwifery workforce FTEs increased by just 144 across the period January 2019 to November 2019

Medical and Dental

- Vacancy rates are at 9.7% (Dec 2019) but some specialisms face particular challenges; consultant vacancy rates are at 8.6%.
- Similar to the picture with Nursing and Midwifery, demand is outpacing recruitment with the Medical and Dental workforce growing by 34.5 FTEs over 2019 whilst budgets increased by 59.6 FTEs
- At a national level, Medical and Dental workforce FTEs grew by 176 across the period January 2019 to November 2019.

Recruitment to Nursing, Midwifery, and Medical & Dental staff groups remains a challenge for BCUHB, as it for other Health Boards, owing to a general shortage of skilled staff. This issue is particularly acute within the following hard to fill specialisms; GPs, Mental Health and Learning Difficulties, General Surgery, Rheumatology, Care of the Elderly, Radiology (particular the specialisms relating to Breast), Gastroenterology and Obstetrics and Gynaecology.

So what are we doing about it?

Retaining our staff

In light of the challenges above, retention of skilled staff remains a key priority. Numerous improvement actions have been enacted since the NHS Wales Staff Survey 2018 organisational improvement plan was approved by the Board in March 2019. All Divisions also have also developed their local improvement plans. In order to ensure staff feedback is a continuous process the organisation invested in a tool which has been branded as 'ByddwchynFalch/BeProud. The tool offers a simple way to understand the science behind staff engagement in terms of cause and effect; provides clear practical recommendations to improve staff engagement; provides regular trend analysis and organisational and team level diagnosis of culture.

BCUHB remains committed to investing in developing our staff. All Leadership & Management Development programmes have been reviewed to ensure compassionate leadership is threaded throughout each programme. Senior leadership development includes a suite of masterclasses and a network which brings together the most senior clinical and non-clinical leaders to develop relationships and develop a cohesive team to ensure organisational and service objectives and improvements are met. Appraisals have increased by 8.6% since April 2019 to 75.5% in January 2020. Processes have been reviewed to ensure compassionate and values based conversations take place at appraisal.

Promoting Train/Work/Live

In order to address the challenges for Nursing & Midwifery recruitment, BCUHB will continue to market itself through Welsh and UK wide recruitment events, promoting the Train/Work/Live North Wales brand. At a local level, the health board is planning this year's calendar of recruitment open days where candidates can be interviewed on the day and walk away with an offer.

- Specific focus is being placed on wards with high vacancy numbers where social media campaigns will be run through Facebook, Twitter and Instagram.
- Whilst we hope to address the majority of our recruitment needs locally, we accept that there is still a need to source candidates from further afield so in Q1 2020/21 BCU will commence a 12 month international recruitment campaign to source circa 200 RNs.
- For Medical and Dental staff a dedicated weekly Medical Recruitment Panel meets to plan and speed up recruitment activity. BCU are also working with external recruitment specialists to help source new recruits into hard to fill specialisms.

Wales for Africa Programmes: International Health Partnerships

The Health Board continues to be a signatory to the Charter for International Health Partnerships (IHP), which recognises the legitimacy of international health engagement, with the aim of bringing knowledge, and skills back to Wales to improve the health of Welsh Citizens along with sharing best practice and working with a range of nations. By engaging in international initiatives, we can learn from others and work to reduce inequalities whilst sharing our own experiences. BCUHB recognises the importance of being engaged in the international health agenda and this is reflected by the International Health Group (IHG) being Chaired by the Executive Director, Nursing & Midwifery / Deputy Chief Executive.

As well as benefitting people in poorer countries who have fewer resources and less developed healthcare systems, involvement in humanitarian overseas work also benefits our staff in a number of ways. These include improving their teaching skills, building leadership confidence, generating ideas for health service delivery within limited resources, learning about the delivery of healthcare to people from different cultures and also gaining direct experience of global diseases that may pose a risk to the population of Wales. This enhanced skill and knowledge can then be used by our colleagues when they return from overseas, for the benefit of patients in North Wales. Teams of local nurses, doctors, midwives, public health specialists, pharmacists, IT experts, researchers and others are involved in our international health links work, most notably as part of the Wales for Africa Programme.

In North Wales, there are active links to healthcare in the Quthing district of Lesotho, hospital care in Hossana Hospital, Ethiopia and primary care and eye care in Hawassa, Ethiopia. More recently, a healthcare in Busia County, Busia County Referral Hospital in Kenya. Over the past year, the Health Board has supported the work of the links by hosting the International Health Group (IHG), developing national guidance, awareness-raising, and by enabling staff to participate in reciprocal visits involving Wales for Africa partners.

Members of the IHG have made a number of overseas visits – including those to Lesotho, Tanzania, Libya, Ghana & Uganda as part of the International Learning Opportunities (ILO) scheme; to Ethiopia to provide hospital informatics support as well as ophthalmology, cardiology and basic emergency department training; to Lesotho to provide mental health and HIV anti-stigma training; and to Kenya on a fact-finding visit as part of plans to establish a new link. Following a successful visit to Busia County Referral Hospital in Kenya, the link is now preparing to undertake a comprehensive health needs assessment (HNA) within Busia County and a second visit is planned for May 2020. The Kenya Link HNA has been funded by the Welsh Government's Wales for Africa Grant Scheme, and is administered by Wales Council for Voluntary Action. The Health Board holds a list of 150 individuals who are either actively undertaking international work, involved in supporting this work, or who have expressed an interest in becoming involved in volunteering. Currently work is in place for planned review of volunteering to strengthen the ability of individuals to participate in opportunities such as IHP. The board encourages all links to work in partnership with local Universities (Bangor and Glyndwr) Universities.

Newly Qualified Nurses

From September, those student nurses on a Welsh Bursary will be expected to remain in Wales for 2 years post qualifying. They do not have to stay in an NHS role but this will improve our retention of students in particular in Paediatrics where we often lose staff to tertiary settings in England.

Improving Quality Together

Through the BCUQI hub improvement, training has been delivered for the last 18 months. So far 123 staff have signed up for Silver IQT, with 73% of them completing all study days. The Silver IQT training now forms part of ward managers training, with two cohorts of managers attending training to date. The improvement training has been standardised through the development of standard operating procedure. The BCUQI hub has opted to go live earlier than launch date (April 2020) of the new improvement in practice training which is replacing Silver IQT with the first cohorts (17 staff) now half way through their face to face training.

As part of the improvement training the BCUQI hub has developed a QI database for improvement projects to be loaded to and shared across BCUHB so others can adopt and learn, the database is also open for others to load there improvement work to as well. The database can be accessed via https://www.bcuqi.cymru/database-1.

Chaplains and Spiritual Care

The Chaplaincy Service delivers pastoral care to staff as well as our patients and their families. In addition, daily pastoral care of our staff, the Chaplaincy, over the last year has introduced new initiatives that encompass a wider spectrum of our world of spirituality. The introduction of guided mindfulness sessions and spiritual concerts have enhanced our service. One such initiative is the monthly gong bath for staff members at Ysbyty Gwynedd - which has proved very successful. These teatime sessions have been over-subscribed and planning is underway for the introduction of yoga sessions soon. Our new Chaplaincy Centre at Ysbyty Glan Clwyd is now operational and provides a modern, multi-faith spiritual centre. The Chaplaincy Centres have also been opened out for use by community self-help groups such as Alcoholics Anonymous and community choirs.

Celebrating success

International Year of the Nurse and Midwife

The World Health Organisation (WHO) has declared 2020 as the International Year of the Nurse and Midwife, in honour of the bicentenary of the birth of the founder of modern nursing, Florence Nightingale.

Worldwide, nurses and midwives play a vital role in providing health services, and they can often be the first and only point of health care in their communities.

Nurses and midwives are the largest workforce globally and provide support across the life course for individuals, families and communities and provide invaluable leadership for health protection and preventative healthcare.

BCU employs over 6000 nurses and midwives across various roles and this is testament to the vital role nursing plays in shaping public health policy and providing leadership to improve the health of the nation.

Throughout 2020, we will be:

- Celebrating the contribution of nurses and midwives in improving global health by supporting national and international events and also holding a number of locally led initiatives
- Attending public events and schools to educate future health professionals on the varying roles available.
- Developing and publishing the BCUHB Nursing strategy

Staff Awards

Seren Betsi Awards

The Seren Betsi Awards is presented every month to recognise an individual or team that goes above and beyond to demonstrate our organisational values. We also present a Seren Betsi Gold Award at the Annual Achievement Awards where an overall winner for the year is selected by public vote.

In Progress

Equality: Fairness, Rights and Responsibilities

At BCUHB our vision is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential, and helps towards reducing health inequalities.

To inform the health board's strategic direction it is essential that we have a clear overview and understanding of the major issues facing people with different protected characteristics. This year we have undertaken a review of our equality objectives. We have drawn on evidence from a range of sources including the Equality and Human Rights Commission research 'Is Wales Fairer?', gathered and analysed relevant information and maintained engagement with communities, individuals and experts to help to further inform our priorities and objective-setting. The SEP can be accessed **(link)**

The promotion of equality and human rights in everything we do is a key underpinning principle within all health board plans and the responsibility of the whole organisation. Progress and more information about the work we have done to advance equality this year is published in our Annual Equality Report 2019-2020 **(link).**

More details about the work we do to promote and support equality can be found in our Annual Equality Report 2019 – 2020.

Special Measures

The Health Board has been in special measures since June 2015. Work has been ongoing to make improvements in line with the expectations of the Special Measures Improvement Framework (SMIF) issued by Welsh Government. During the first half of this reporting period, the Framework covered four themes: leadership & governance, strategic & service planning, mental health and primary care. In November 2019, the Minister for Health & Social Services issued a revised SMIF covering the four themes of leadership and improvement capability, strategic vision and change, operational performance and finance and use of resources. This latest version of the SMIF is split into Part A: expectations to be met as a minimum in order to be de-escalated from special measures, and Part B: characteristics the Health Board will need to demonstrate it is sustaining and building upon in order to step down to routine arrangements status.

The organisation undertook a self-review in December 2019 against Part A expectations. The self-review identified progress made over the past year. This included quality improvements such as the increased use of integrated dashboards for a range of data/intelligence; the requirement under the Ward Accreditation Programme for wards to undertake quality improvement projects driven by concerns and patient feedback and a range of “Going for Gold” quality improvement roadshows.

Initiatives to improve patient safety during special measures include the launch of an upgraded Harms Dashboard; establishment of the In-Patient Falls Collaborative to support areas with higher levels of harm, and delivery of winter plan initiatives such as increasing multidisciplinary team capacity and projects to support patients’ recovery in their own homes. Infection control work has led to a reduction in the number of cases of MRSA.

The work undertaken has led to a variety of improvements to the patient journey, such as the launch of the new Patient Advice and Liaison Service with hubs established at each District General Hospital; reconfiguration of beds and processes on the Wrexham site to create ambulatory and short stay medical capacity located close to the Emergency Department; and the SiCAT model of assessment and triage which has demonstrated a significant contribution to signposting patients to alternative care pathways.

Despite the progress made against the expectations of the revised Special Measures Improvement Framework, that a number of milestones, most notably in the key areas of finance, planning and performance (planned and unscheduled care), have not been fully achieved and it is recognised that there is considerable further work to be done to address the ongoing challenges. The Board remains fully committed and determined to achieve the required improvement in order to secure de-escalation from special measures.

Forward Look 2020/2021

Our vision and purpose is to create a healthier North Wales, that maximises opportunities for everyone to realise their full potential and reduce health inequalities in our population. Therefore, putting quality first in everything that we do to deliver outstanding healthcare to our local population is essential, and we will continue to do so. We have seen so many members of staff embrace quality improvement, and continuously raise standards and improve outcomes for our patients. Our Three Year Outlook and 2020/21 Annual Plan is the end product of a fully integrated process, which has taken account of service, quality and safety, financial and workforce considerations to ensure we have a coherent, consistent, and ambitious set of actions and deliverables.

This work will be guided by the principles within the Well-being of Future Generations Act, and together with our partners across the public and voluntary sectors.

Our **ambition** for 2020/23:

Exit Special Measures		
Maximising our partnership working to deliver on the health inequalities and health improvement agenda	Implementing our model of Primary Care to ensure people have easy and timely access to services and deliver health and care support as close to people's homes as possible	Implementation of digitally enabled clinical pathways supporting timely access to safe and effective planned and unscheduled care in accordance with clinical need with the best possible outcome
Engage more widely and refine our digitally enabled clinical strategy proposals. Resources will be required for delivery of this ambitious strategy, which will include investment in digital systems and the requisite supporting staff, new workforce skills and capabilities, organisational development support, and a steering group to oversee the development of the strategy.		

Our priority for action in **2020/21** is to make significant progress towards achievement of the following objectives.

Quality Improvement	
Strategic Vision and Change Developing a digitally enabled clinical strategy with our staff and partners	**Improved Operational Performance and Governance** Focussing our improvement in the following key metrics: - Planned care / Referral to treatment - Unscheduled care
Strengthened Leadership and Improvement Capability Supporting our key service transformation programmes:	**Financially Sustainable**

- Health inequalities and health improvement - Care closer to home	- Using our resources effectively - Moving towards a sustainable financial position

Covid-19

Cyfarfod a dyddiad: **Meeting and date:**	**Quality, Safety and Experience Committee** **3.7.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	BCUHB Corporate Safeguarding Annual Report 2019-2020
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris, Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Michelle Denwood, Associate Director of Safeguarding
Craffu blaenorol: **Prior Scrutiny:**	Corporate Safeguarding Team
Atodiadau **Appendices:**	Appendix 1: Safeguarding Adults Report Appendix 2: Safeguarding Children's Report

Argymhelliad / Recommendation:

The Committee is asked

- to note the progress made this year by the Corporate Safeguarding Team, particularly in relation to the recognised improvements and outcome of the Peer review of the Assurance Framework of the National Safeguarding Maturity Matrix (SMM)

- Recognise the significant improvement to achieve Substantial Assurance as an outcome of the Internal Audit of BCUHB Safeguarding Governance review.

- approve the Corporate Safeguarding Priority Action Plan for 2020-2021.

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

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

Sefyllfa / Situation:

The purpose of this report is to present an overview of the activity driven by the Corporate Safeguarding Team during 2019-20. The key issues are highlighted within this report with additional references made to the two (2) supporting appendices; Adults at Risk Annual Report 2019-2020, the Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Annual Report 2019-2020.

The two (2) appendices reference the operational and strategic work undertaken by the Corporate Safeguarding Team, Children and Adult at Risk, safeguarding within the Mental Health and Learning Disability Division (MHLD), the Deprivation of Liberty Safeguards (DoLS) and the Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) agenda. Each area of practice is referenced within the key domains of the National Safeguarding Maturity Matrix (SMM).

The SMM is a quality outcome monitoring tool with the aim of capturing and collating a national SMM providing assurance, share practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales. This is overseen by the Chief Nursing Office for Wales. The self-assessment scoring for 2019 in comparison to the 2018 scores demonstrates significant progress in relation to BCUHB's assurance regarding safeguarding arrangements. Currently BCUHB have an overall position score of 23 out of 25 which is currently the highest in Wales. The appendices also provide information specific to Corporate Safeguarding's performances and data collection.

Cefndir / Background:

Assurance

The BCUHB Corporate Safeguarding Annual Report 2019-20 is an overview of the ongoing development and implementation of the safeguarding agenda which is complex, challenging and developing with pace.

Governance and Performance

The continued improvements are evidenced by the findings of the NHS Wales Shared Services Partnership Audit and Assurance Service. An internal review covering the period of 2017/18 was completed, this was a detailed review of service delivery against the requirements of the Health and Care Standards, Safeguarding legislation and guidance. The result was found to be Limited assurance.

However, a Follow-up internal review of the period of 2019-2020 found Substantial Assurance. No recommendations were made following this audit as reported findings had evidenced significant improvements had been made.

Deprivation of Liberty Safeguards Audit (DoLS)

As part of the Safeguarding activity plan a review of the DoLS process commenced prior to December 2019. DoLS was previously managed within the portfolio of the OMD and was transferred into the portfolio of the Executive Director of Nursing and Midwifery and forms part of the Safeguarding portfolio. A review of the service was highlighted as an important key objective for DoLS in the 2018/19 Safeguarding annual report.

This was the first audit of this service provision by BCUHB. The internal review was completed in March 2020.It was recognised although progress had been made during this period; the outcome of the audit was Limited Assurance and identified five (5) key recommendations.

All recommendations have been implemented with the exception of the appointment of the remaining one (1) BIA post. Progress has been made and the employment and recruitment processes is being followed.

Priority	**H**	**M**	**L**	**Total**
Number of recommendations	**3**	**2**	**0**	**5**

Key activities were;

- The development of a Standard Operating procedure to support National guidance documents
- Engagement and training for Authorisers (Signatories)
- Enhanced monitoring, training and review of DoLS National Forms
- Secured funding and recruitment to the final Best Interest Assessor (BIA) post
- Include Datix incident reporting within the Standard Operating Procedure and Training.

Safeguarding Maturity Matrix (SMM)

The Safeguarding Maturity Matrix (SMM) has been piloted across all Health Boards/Trusts in Wales for the past two years. It has been agreed the self-assessment of safeguarding arrangements will continue for a third year, 2020-2021.

In November 2019, the five standards assessed were; Governance and Rights Based Approach, Safe Care, ACE Informed, Learning Culture and Multi Agency Partnership Working. The highest achievable score is five for each standard, with a maximum score of 25.

BCUHB achieved a score of 14 in 2018, and a score of 23 in 2019. This demonstrates excellent progress, and is the highest score in Wales, this was achieved by the implementation of improved Governance, Performance and assurance Frameworks, Evidenced Based learning, and the development of Communication pathways.

Performance and Triangulation of Data.

The development of a performance framework for Child and Adult at Risk Reports provides the Corporate Safeguarding Team with triangulated data and highlights organisational compliance, provides assurance and the ability to benchmark performance against key national indicators. It enables an improved proactive approach to be taken rather than a reactive approach and this is supported by the strategic agenda.

Training is in a constant state of change due to the regular introduction of new legislation and policy. Corporate Safeguarding have adapted to the training needs of our diverse workforce and have introduced a variety of learning tools to promote a culture of learning. The development of enhanced training packages has been referenced and implemented on a National basis due to the recognition of a proactive and leading service.

Safeguarding training compliance, in general, continues to rise and this demonstrates the positive engagement and ownership of safeguarding responsibility across all services and divisions. However, Corporate Safeguarding have identified key target areas for improvement and will continue to engage these services to support greater compliance and evidenced learning.

Multi-agency agenda

The agenda and legislative footprint is vast and requires multi-agency partnership working. The Annual Report evidences that there is improvement with this engagement and that it is sustained.

The Welsh Governments independent review of the Safeguarding Adult Board evidenced BCUHB's valued engagement with our agency partners. It noted the increased BCUHB membership, and the influence and impact made by the Associate Director for Safeguarding. BCUHB's transparency, within all safeguarding activities is an important aspect and improves trust, engagement between patients, professionals, families, advocates and members of the public. Having learnt from previous incidents, Corporate Safeguarding have embedded a progressive working culture that has helped to achieve positive results internally and with external partner agencies, with communities, and with individuals. This is evidenced in multi-agency Desk top reviews and Safeguarding Reviews, namely Adult Practice Reviews, Child Practice Reviews and Domestic Homicide Reviews.

The review of Regional Partnership Boards is ongoing, BCUHB and Corporate Safeguarding remain fully engaged.

Asesiad / Assessment & Analysis

Strategy Implications

Policy and Procedures

Adult Safeguarding became a statutory requirement following the introduction of the Social Services and Wellbeing (Wales) Act in 2014. On November 4th 2019, the Welsh Government introduced the Wales Safeguarding Procedures to support safeguarding activity in Wales.
An agreement was reached across Wales to launch the Wales Safeguarding Procedures in April 2020 but due to the impact of the COVID-19 pandemic, it was further agreed to delay the launch until September 2020.

Clear guidance, accessibility and accuracy are important factors when referencing Safeguarding Policy and Procedures. The table evidences the increase in the development and revision of safeguarding policies, procedures and protocols, which supports the organisation to protect service users and their families.

Safeguarding Policy/Procedure/SOP	2017- 2018	2018-19	2019-20	Trajectory
Number In Date	3	8	14	
Number Under Review	0	6	2	
Number out of Date	10	0	0	
Total Number	13	14	16	

At the beginning of March 2020, there was a significant change in service delivery as a response to the global COVID-19 pandemic. Corporate Safeguarding has offered full engagement and support to all services within BCUHB in the identification of potential risk, the mitigation of this risk, and to ensure that safeguarding awareness activity is paramount. In particular, and due to the reduction in face-to-face contact with our vulnerable patients in the community, Corporate Safeguarding have worked with commissioned care services to explore ways in which patient safety and wellbeing can be monitored to allow for absolute assurance in relation to their continued health, wellbeing and safety.

BCUHB's Adult Safeguarding strategy has been updated and amended to ensure that adults at risk of abuse or neglect are supported to achieve their identified outcomes. This 'making safeguarding

personal' approach is an acknowledgment of the current legislation and the comments received from the board in relation to the reporting and recording of 'real' outcomes.
The impact of the changes made has had an immediate effect on patients and services as these outcomes, and the learning from these outcomes, are embedded into future practice to sustain health and wellbeing and prevent further abuse or neglect.

The early identification and reporting across BCUHB has been acknowledged by the North Wales Local Authorities, Police and other partner agencies, with positive feedback received specifically in relation to BCUHB's implementation of the HASCAS/DO recommendations, our transparency in reporting concerns, and the immediate actions taken to make the patient and/or the situation safe, which is paramount within safeguarding. Older People Mental Health remains a high Safeguarding risk area, therefore significant input from Corporate Safeguarding as seen resulted in three (3) desktop reviews for learning and to support the implementation of procedures to mitigate risks to this vulnerable patient group.

Prevention and Identification

Safeguarding Adult, Adult MHLD, and DoLS data recording, this information supports the identification of key safeguarding priorities. The Corporate Safeguarding team utilise the organisations data to benchmark against potential risk to facilitate immediate mitigation and learning. This is communicated across BCUHB using the Safeguarding Communication Strategy, utilising Safeguarding Performance and Governance meetings, area safeguarding forums, monthly bulletin reports, and the updated Corporate Safeguarding webpage to ensure divisional and service compliance and assurance.

BCUHB's engagement within operational and strategic safeguarding partnership meetings, locally, regionally and nationally, have supported key developments that have impacted positively and improved internal services.

It is evident that during early 2020 Adult Safeguarding reports increased in comparison to the data from 2019. Due to the COViD-19 pandemic a reduction in reporting was identified for April 2020. The development of a Safeguarding COViD 19 action Plan has supported activities to enhance and continue to ensure staff engage with service users. Engagement and communication with the workforce has continued, supporting decision making and ensuring reporting continues. This is evident in the immediate increase in reporting during May 2020 and as shown in the Table below.

Adults Safeguarding Reports	2019	2020	2020 Reporting Trend
January	75	99	
February	91	118	
March	92	117	
April	107	72	
May	103	106	

From May 2019, Child at Risk performance data is readily available to BCUHB. This data provides the Corporate Safeguarding Team and the wider services areas with trends and themes in relation to Child at Risk Reports that have been generated.
The identification of areas of high Child at Risk activity, referrer's designation and the age of 'at risk' children supports the strategic intervention, but informs practice at all levels within the organisation. The information is invaluable in ensuring safeguarding support and training is delivered in these high-risk areas, and provides data to allow for targeted resources to meet the demand, aiming to minimise further potential risks to children.

The number of Safeguarding Children reports being received from the community and those from secondary are settings are very comparable. For 2019-20, the number of reports from the community total to 1417 and those from the acute sites total to 1381.

The highest referrers to children's safeguarding in 2019-20 were;

- Emergency Department – 982 reports – 35%
- Health Visitors – 486 reports – 17%
- Midwives – 479 reports – 17%
- CAMHS – 283 reports – 10%

The data demonstrates a reduction in Child at Risk Reports, during the period of March 2020 during the COVID-19 pandemic. The rationale is nationally recognised as there were fewer children being seen in the Emergency Department during this time and less face-to-face contacts were being carried out by midwives and health visitors and school nurses.

A priority activity for 2020-2021 is to fully implement the Child at Risk Performance Reporting Framework to include outcomes of the Report and to identify themes of abuse.
This will provide BCUHB with additional invaluable qualitative data, focussing on outcomes, and not solely relying on quantitative data, which cannot provide the complete picture when safeguarding children at risk. This work is a good example of BCUHB working very closely with their Local Authority partners.

Safeguarding Supervision, Advice and Guidance

The principles underpinning safeguarding children supervision is in the Children Act (1989) and (2004) (section 28) and in Safeguarding Children; Working Together under the Children Act 2004 (2006) Section 14. Safeguarding children supervision is embedded within the organisation and has clear evidence for improving the outcomes for children and their families.

During 2019-2020, this supervision was offered, to not only health visitors and school nurses, but to those areas who deliver services to children at risk, for example Child and Adolescent Mental Health Services (CAMHS) and Looked after Children Nurses (LAC). This has created a safer and supportive workforce in high-risk areas where children access services.
The Supervision procedure also supports supervision for practitioners engaging in activities to support Adults at Risk, this is encouraged and will be a valuable activity when the new Wales Procedures come into force, due to the increased demands and complexity.

Due to the findings of a Child Practice Review, following a traumatic death of a baby, the Corporate Safeguarding Team implemented the Trauma Risk Management (TRiM) process. Early identification of staff exposed to trauma, aids in promoting a healthy workforce by supporting the welfare needs of

staff, and contributes towards reducing staff absence. Full evaluation of the process will be available in 2020-2021 Annual Report. Two TRiM assessments have taken place due to the exposure of staff to traumatic incidents.
The feedback has been extremely positive, the wellbeing of employees is of paramount importance and this activity supports staff, enhances learning and improves service delivery.

Culture of Learning

By promoting a positive culture of multi-agency learning/audits across the Health Board supports improvements in service delivery and practice. All National, Regional and Local Child Practice Reviews and Adult Practice Reviews are reviewed and any identified learning is embedded into practice. A good example is the audit being conducted across the three Emergency Departments by the implementation of weekly safeguarding meetings The initial pilot demonstrated positive outcomes in safeguarding children.

In 2018-19 an audit undertaken by the North Wales Safeguarding Children Board together with the learning from a Child Practice Review, identified that a review of the Health Pre-Birth Assessment (HPBA) was required. This audit has resulted in the identification of improvements in documentation, of poor compliance in reviewing the HPBA and the sharing of the HPBA with Local Authorities. A re-audit will be conducted in 2020-2021.
As part of the NHS Wales Safeguarding Network Work Plan, the Head of Safeguarding Children BCUHB and a Designated Nurse National Safeguarding Team PHW, agreed to conduct a review of the All Wales Antenatal Routine Enquiry into Domestic Abuse within NHS Wales. The audit provided the authors with a national picture in relation to how the All Wales Routine Enquiry into Domestic Abuse is being implemented across Health Boards in Wales. In addition, it provided information relating to compliance with the All Wales Minimum Standards. A set of recommendations have been identified and will be monitored within the NHS All Wales Safeguarding Network Work Plan 2020-2021.

Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) places an increased demand upon the service. The Harm agenda, County Lines, PREVENT, Modern Day Slavery and Female Genital Mutilation (FGM) are all recognised as a criminal offence and can result in both Adult and /or Child abuse.

BCUHB provide quarterly reporting to Welsh Government regarding FGM with the majority of cases identified by the Women's Division. During 2020, wider FGM training has been delivered in high-risk areas, such as sexual health services, cervical cytology and in the Sexual Abuse Referral Centre (SARC). It will be interesting to note if the number of identified FGM cases increases in 2020-2021

BCUHB recognises that within its workforce there will be employees who have experienced, or who are currently experiencing domestic violence and abuse, as well as employees, who are perpetrators or alleged perpetrators. The VAWDASV Workplace Procedure was implemented in September 2019 to support victims and perpetrators and includes the development of Workplace Safety Groups across the region.

Financial Implications

Corporate Safeguarding are aware of the current financial challenges faced by BCUHB. However, Safeguarding is an ever-increasing agenda that requires increased governance and engagement to ensure that BCUHB adhere to legislation and policy, are able to offer assurance with regard to the wellbeing and safety of patients and professional practices, and maintain their leading role in developing and promoting the safeguarding agenda.

Having identified the need to strengthen the Corporate Safeguarding team structure, as recorded in HASCAS recommendation 8 and Donna Ockenden recommendation 6, A further paper has been presented to the BCUHB Quality Safety Group (QSG) on the 10.1.20, in line with HASCAS / DO recommendations reflecting safeguarding and the Deprivation of Liberty Safeguards. This relates to the review and effectiveness of the Corporate Safeguarding team structure and the progress report relating to the DoLS 2017-2018 action plan and revised legislation and the current demand. A further business case is being developed.

There are financial implications for the health board in relation to the implementation of The Liberty Protection Safeguards (LPS) that formulate part of the Mental Capacity (Amendment) Act 2019. The anticipated Code of Practice will set out in detail practical guidance.

The financial impact for LPS is wide ranging with a change of roles and responsibilities across the Health Board. LPS no longer relies upon the current deprivation of liberty safeguards (DoLS), where Best Interest Assessors (BIAs) and S12 (2) Doctors are solely responsible for the assessments. Under LPS the BIA will have greater responsibility and accountability as the Act dictates that Health Boards will retain ownership of LPS for all commissioned patients.
This will see a huge increase in assessment requests that if not completed could result in legal and financial implications. The appendices provide detailed assurance measures to be taken to mitigate against any risk.

Risk Analysis

Corporate Safeguarding currently record that there is a risk that the Health Board does not discharge its statutory and moral duties in respect of and with regards to Safeguarding Adults / Children / Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and the Deprivation of Liberty Safeguards [DoLS] by both recognising the activities of the Managing Authority and Supervisory Body.

This may be caused by a failure to develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity. This could further impact on those persons at risk of harm to whom BCUHB has a duty of care, with particular reference to the added challenges due to the National guidance by Welsh Government relating to COVID-19.

The current risk is reported at 16 with a target risk of 12.
Due to the nature of the service, unfortunately governance arrangements, training and engagement with partner agencies cannot prevent the unexpected death of a child or adult by another person. The research and national picture recognises that this is likely to happen and the outcome is catastrophic.

In mitigation Corporate Safeguarding have implemented cycle of business planning meetings within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding. A refreshed Safeguarding Reporting Framework has been applied which sets out clear lines of accountability and is underpinned by the Cycle of Business. A standardised data report on key areas, including Adult at Risk, Child at Risk and DoLS is submitted to BCUHB Safeguarding Forums in order that data is scrutinised, triangulated and risks identified.

A programme of Risk Management has been embedded into the processes of the Reporting Framework by being included as a standing item on the Safeguarding Governance and Performance forum agendas. Within these meetings issues of significance reports require that risks are to be identified and reported to ascertain assurances and completion of mitigating actions.

The new Senior Management tier, in line with HASCAS 8 / DO 6 has been implemented within the Safeguarding Structure. This will continue to support strategic oversight in key areas.
The implementation of the identified priority actions for 2020-2021 will further strengthen the organisations Safeguarding governance and performance activities, with the aim to safeguard service users, families and employees who access our services.

Legal and Compliance

Safeguarding is underpinned by legislation, policy and procedure. The role of Corporate Safeguarding within BCUHB is to ensure that the Health Board execute their responsibilities and comply with the Safeguarding legislation, providing assurance that the strategic measures are implemented, audited and reviewed.

The legislative requirement is met due to the adaptation into practice and service delivery of key local, regional, national and international legal frameworks that dictate the agreed working protocols from which BCUHB develop their internal policies and procedures. Key documents include the Social Services and Wellbeing (Wales) Act 2014, the Human Rights Act 1998, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards 2005 (amendment), and the VAWDASV (Wales) Act 2015 and Children Act 1989 and 2004.

Impact Assessment

The methodology set within the report remains under continuous review by the Associate Director for Safeguarding. Any changes to this will be brought to the Board's attention for approval or ratification.

All documents that impact upon patients, staff or the organisation are completed in line with a supporting EqIA, and having engaged with stakeholders to ensure broader potential impacts. Assurance can be given that any possible equality, quality and governance impact has been measured into the drafting of the report.

Corporate Safeguarding Priority Actions 2020-2021

Red	Incomplete
Amber	Partially complete
Green	Complete

All 2019-2020 Priority Actions with the exception of PR11 have been completed, this is due to the delay in the National guidance, and the priority activities due to COViD 19. All activities are referenced within the detailed Corporate Safeguarding Reports for Adults and Children.

All activities are strategically supported and Quality Assured by the Associate Director of Safeguarding and agreed following the Safeguarding Assurance Framework.

Ref	Comments	Timescale / Person Responsible	Comment	Rag Status
PR1	Raise awareness and compliance of the Wales Safeguarding Procedures for Adults.	HoSA PDL 30/09/20	The introduction and implementation of the Wales Safeguarding Procedures will result in the change of role for BCUHB staff within the safeguarding process. Work is ongoing to ensure the workforce are fully aware of their responsibility and that support will be readily available once the Procedures go live.	Amber
PR2	Progress the multi-agency County Lines agenda and engage in the County Lines Needs Assessment Task Group.	HoSA 31/03/21	County Lines poses a multi-agency risk across the UK. In North Wales activity is monitored via the Serious Crime Board which is attended by BCUHB. The Needs Assessment Task Group is looking at ways in which all agencies can support and help reduce future risk.	Amber

PR3	Increased engagement with BCUHB contract and commissioning services to review the Safeguarding standards, policies and procedures of external care providers.	HoSA HoSA/MHLD 31/03/21	To ensure that BCUHB supported patients are safeguarded within their home, private hospital, or community setting there is a need to review measures in place that offer assurance.	Amber
PR4	Review Adult Safeguarding Performance and Governance activity across BCUHB.	HoSA 31/03/21	Work in line with guidance and adhere to processes and procedures specific to corporate safeguarding and the organisation. Ensure divisions are aware of safeguarding responsibilities and the reporting and governance framework.	Amber
PR5	Review, action and put into practice learning from local, regional and national Adult Safeguarding Reviews to benchmark BCUHB service compliance.	HoSA 31/03/21	Source current reviews and enquires recommendations. Produce action plan to benchmark against current BCUHB practices. Identify areas of concern, work in partnership to ensure learning from internal/external reviews is shared across the organisation. Not to let slip on actions and create process for divisions/services to continually review their practices.	Amber
PR6	Implement the revised Level 3 MHLD training programme to obtain a minimum 85% target, this is to include the ICAN volunteers.	HoSA/MHLD PDL 31/03/21	Following extensive engagement and partnership working further work required to embed the training and monitor compliance across the division.	Amber
PR7	To support on the implementation of a multiagency co-produced MHLD guidance for patients and staff specific to Sexual Safety.	HoSA/MHLD 31/03/21	The co-produced guidance has been completed in draft form. Corporate Safeguarding to support the wider review and implementation across MHLD.	Amber

PR8	Successful recruitment of all vacant posts within Corporate Safeguarding and consideration of the wider structure.	SBM HoSA HoSA/MHLD HoSC 31/12/20	Consider the additional Band 7 Safeguarding MHLD Specialists for each area	Amber
PR9	The DoLS Forms created by W.Gov in 2015 and used by BCUHB are found to be inaccurate or legally deficient which can lead to a legal challenge so need revising	SSDoLS 31/10/20	A W.Gov grant secured 31/03/20 to support a review of DoLS forms by a legal expert in the field of DoLS. Memorandum of Understanding created and approved by QSE on 12/06/20	Amber
PR10	All professional staff to have an induction on the impact and implementation of LPS which replaces DoLS	SSDoLS 30/11/20	Memorandum of Understanding put in place with external expert to create e-learning training package that can be accessed by all professional staff in BCUHB. MoU Approved by QSE on 12/06/20.	Amber
PR11	Impact Risk Assessment to be developed to consider risk and mitigation for the implementation of LPS across Health Board	SSDoLS Original date for completion was 1.4.20, revised proposed completion date is 30/08/20	Brought forward from 2019/20 Strategy Steering Group to be identified and established involving key stakeholders.	Red

PR12	Full implementation of the Child at Risk Performance Reporting to include outcomes of the Report and themes of abuse	HoSC 30/08/20	Work has commenced with the LA's in capturing outcomes of Child at Risk Reports. All LA's agreed to engage in this process	Amber
PR13	To produce quarterly Child at Risk Performance Reports which are shared at the relevant forums holding Divisions to account.	HoSC 31/07/20	Reports will be developed by the Safeguarding Data Analyst on a quarterly basis. These will be shared at each area safeguarding forums	Amber
PR14	Full implementation of a standardised Regional Safeguarding Supervision Database to ensure the collection of consistent and meaningful data.	HoSC 31/07/20	The HoSC will meet with the 3 Area Safeguarding Managers and the Data Analyst to develop a standard data collection tool. Quarterly data will be develop ensuring all managers are aware of their team position in relation to compliance with safeguarding supervision	Amber
PR15	To complete the audit in relation to weekly safeguarding meetings in the three ED's, arising from the Cardiff and Vale CPR, and complete a full evaluation report and action plan	HoSC 31/03/21	The audit is currently in progress	Amber
PR16	To fully monitor and evaluate the TRiM Process across BCUHB and provide feedback to the North Wales Safeguarding Children Board	HoSC 31/12/20	Currently in progress	Amber

PR17	To complete the BCUHB Action Plan in relation to the Mid and West Wales CPR and fully embed the learning into current practice	HoSC 31/12/20	Currently in progress	Amber
PR18	To undertake the HPBA Audit for 2020-2021 to provide assurance of improvement and compliance	HoSC 01/04/21	Currently in progress Quarterly reporting will be implemented	Amber
PR19	To develop an Action Plan for the findings in the HPBA Audit 2019-2020 to provide assurance that the actions are monitored and completed	HoSC 30/06/20	Currently in progress and Audit activity is supporting ongoing activities	Amber
PR20	To ensure ratification of the Coping With Crying Guidance and to receive from the NSPCC the updated film and training materials in order to improve practitioners knowledge	HoSC 30/09/20	This procedure has been disseminated for consultation and comments are being considered	Amber
PR21	To undertake the Routine Enquiry Domestic Abuse Audit for 2020-2021 to provide assurance of improvement and compliance	HoSC 01/04/21	Currently in progress	Amber
PR22	To develop an Action Plan for the findings in the Routine Enquiry Domestic Abuse Audit 2019-2020 to provide assurance that the actions are monitored and completed	HoSC 30/06/20	Completed. Full dissemination of the agreed action plan, with timescales and with a recognised audit schedule to ensure continued assurance.	Green

PR23	To ensure Corporate Safeguarding fully engage in the NHS Wales Safeguarding Network Work Plan 2020-2020 in respect to the recommendations of this review.	HoSC 31/03/21	Meeting of the National VAWDASV Steering Group to be held on the 30th June 2020 to discuss the recommendations	Amber
PR24	Engage and support the review of contracts for Advocacy Services	HoSA 31/03/21	Develop a consistent commissioned service that meets the needs of service users	Amber

Resources Key	
ADoS	Associate Director of Safeguarding
HoSC	Head of Safeguarding Children
HoSA	Head of Safeguarding Adults
HoSA/MHLD	Head of Safeguarding Adults MHLD
SSDoLS	Safeguarding Specialist - DoLS
SSDem	Safeguarding Specialist - Dementia
PDL	Practice Development Lead
SBM	Safeguarding Business Manager

BCUHB Corporate Safeguarding Team
Safeguarding Adults
Annual Report 2019-2020

1. Introduction

1.1 This report incorporates Adult Safeguarding, Adult Mental Health Learning Disability (MHLD) Safeguarding, and the Deprivation of Liberty Safeguards to include Mental Capacity Act (MCA) work within BCUHB Corporate Safeguarding for 2019 – 2020.

1.2 The activity recorded provides oversight and organisational assurance. The priority actions associated with the Corporate Safeguarding work plan are evidenced within the embedded 2020- 2021 Strategic Priorities.

1.3 The report is presented within the key domains of the National Safeguarding Maturity Matrix (SMM). The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of capturing and collating a national SMM providing assurance, share practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

1.4 From March 2020 there has been a significant change in service delivery as a response to the global COViD-19 pandemic. Corporate Safeguarding has offered full engagement and support to all adult services.

2. Governance and Rights Based Approach

Rationale

2.1 There should be a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of children and vulnerable adults.

2.2 NHS Wales Shared Services Partnership Audit and Assurance Service.

2.2.1 An internal review covering the period of 2017/18 took place. A detailed review of service delivery against the requirements of the Health and Care Standards, Safeguarding legislation and guidance. The result being Limited assurance.

2.2.2 A Follow-up internal review of the period of 2019-2020 found Substantial Assurance. No recommendations were made following this audit as reported findings had evidenced significant improvements had been made.

2.3 Deprivation of Liberty Safeguards Audit (DoLS)

2.3.1 As part of the Safeguarding activity plan a review of the DoLS process commenced prior to December 2019. DoLS was previously managed within the portfolio of the OMD and was transferred into the portfolio of the Executive Director of Nursing and Midwifery and forms part of the Safeguarding portfolio. A review of the service was highlighted as an important key objective for DoLS in the 2018/19 Safeguarding annual report.

2.3.2 This was the first audit of this service provision by BCUHB. The internal review was completed in March 2020.It was recognised although progress had been made during this period; the outcome of the audit was Limited assurance and identified five (5) key recommendations.

2.3.3 All recommendations have been implemented with the exception of the appointment of the remaining one (1) BIA post. Progress has been made and the employment and recruitment processes is being followed

Table 1

Priority	**H**	**M**	**L**	**Total**
Number of recommendations	**3**	**2**	**0**	**5**

2.3.4 Key activities were:

- The development of a Standard Operating procedure to support National guidance documents
- Engagement and training for Authorisers (Signatories)
- Enhanced monitoring, training and review of DoLS National Forms
- Secured funding and recruitment to the final Best Interest Assessor (BIA) post
- Include Datix incident reporting within the SoP and Training.

2.4 The HASCAS Investigation and Donna Ockenden Review

2.4.1 The HASCAS Improvement Group monitors the implementation and progress of all recommendations (see Table 2) across BCUHB. The Associate Director of Safeguarding was a standing member of this group and reported on progress, and compliance.

Table 2

Reference	**Recommendation**	**Recommendation Position**
HASCAS 4	Safeguarding Training	Implemented
HASCAS 5	Informatics, and Documentation	Implemented
HASCAS 6	Policies and Procedures	Implemented
HASCAS 7	Tracking Adult at Risk across North Wales	Implemented
HASCAS 8 /Ockenden 6	Review and implementation of the Corporate Safeguarding Team Structure	Ongoing (Delayed due to COViD 19)
HASCAS 12 /Ockenden 9	Review of the Deprivation of Liberty Safeguards (DoLS) work plan identified in 2017-18 for implementation in 2018-19 into 2019-2020	Ongoing (Delayed due to COViD 19)

2.4.2 HASCAS Recommendation 8 / has progressed with the appointment of the Head of Adult Safeguarding, and the Head of Adult Safeguarding MHLD in 2019. There remains vacancies within the Corporate Safeguarding Team as part of natural turnover of recruitment.

2.4.3 Recommendation 12 / 9 relates to a formal audit of DoLS. The remaining recommendation is the recruitment to the service, which is in progress. In addition, a Business Case is to be discussed at the Finance and Performance Group.

2.4.4 Stakeholder engagement has continued successfully through 2019 – 2020 to ensure transparency and true partnership working; this has included stakeholder attendance at Safeguarding training during 2019.

2.5 Safeguarding Maturity Matrix (SMM)

2.5.1 The Safeguarding Maturity Matrix (SMM) has been piloted across all Health Boards/Trusts in Wales for the past two years. It has been agreed the self-assessment of safeguarding arrangements will continue for a third year, 2020-2021.

2.5.2 In November 2019,. The five standards assessed were Governance and Rights Based Approach, Safe Care, ACE Informed, Learning Culture and Multi Agency Partnership Working. The highest achievable score is five for each standard, with a maximum score of 25.

2.5.3 BCUHB achieved a score of 14 in 2018, and a score of 23 in 2019. This demonstrates excellent progress, and is the highest score in Wales.

Priority Action - 8

Successful recruitment of all vacant posts within Corporate Safeguarding and consideration of the wider structure.	Dec 2020

2.6 Safeguarding Governance and Reporting

2.6.1 To ensure organisational reporting, escalation and engagement the Corporate Safeguarding Team continue to work using an agreed Safeguarding Reporting Framework. The Performance and Scrutiny Task Group enables the triangulation of data, performance measures and evidence.

2.6.2 This framework fully supports internal escalation, multi-agency and partnership working, and supports the implementation of the statutory and legislative framework for engagement at both a strategic and operational level. During 2019-2020 Corporate Safeguarding have reported 100% compliance for engagement at both the Adults and Children's Boards and supporting sub groups.

Priority Action - 4

Review Adult Safeguarding Performance and Governance activity across BCUHB.	March 2021

2.7 Safeguarding Policies, Procedures and Standard Operating Procedures.

Table 3 evidences the increase in the development and revision of safeguarding policies, procedures and protocols, which supports the organisation to protect service users and their families.

Table 3

Safeguarding Policy/Procedure/SOP	2017- 2018	2018-19	2019-20	Trajectory
Number In Date	3	8	14	
Number Under Review	0	6	2	
Number out of Date	10	0	0	
Total Number	13	14	16	

2.8 Wales Safeguarding Procedures (Adults)

The procedures are reflected within BCUHB safeguarding policy. The new National Safeguarding procedures have a 'go live' date of September 2020.

Priority Action - 2

Raise awareness and compliance of the new Wales Safeguarding Procedures for Adults.	September 2020

2.9 Adults at Risk – Performance and Activity

2.9.1 In 2019-20, there were 1219 adults reported under the Adult at Risk process (Table 4). This represents a 10% increase on reporting over the previous year.

Table 4

2019-20	West	Central	East	Out of Area	Total
Reports	387	448	378	6	1219

2.9.2 A significant amount of work has been undertaken by the Corporate Safeguarding Team to ensure BCUHB continues to comply with statutory legislation.

2.9.3 It is evident that during early 2020 Adult Safeguarding Reports increased in comparison to the data from 2019 as seen in Table 4.

2.9.4 Due to the COViD-19 pandemic a reduction in reporting was identified for April 2020. This is in line with the National picture.

2.9.5 A COViD action Plan has supported activities to enhance and continue to engage with service users. Engagement and communication with the workforce has continued, the Monthly Safeguarding Bulletin and the Safeguarding Web Page continue to provide support and guidance on a regional basis. This is evident in the immediate increase in reporting during May 2020 and as shown in Table 5.

Table 5

Adults Safeguarding Reports	2019	2020	2020 Reporting Trend
January	75	99	
February	91	118	
March	92	117	
April	107	72	
May	103	106	

2.9.6 Physical abuse, followed by Neglect are the most reported categories of abuse. The high number of recorded physical abuse cases is a result of the legal requirement to report incidents of alleged physical altercations between patients.

2.10 Location of Alleged Abuse

2.10.1 The number of Adult at Risk Reports submitted are comparable across the three localities with a slight increase in community reporting in Central. This is due to the high number of Residential and Nursing Care Homes in this area and the number of patients supported.

2.10.2 The MHLD division reported the highest number of safeguarding reports in 2019-20, making up 43% of the total for the year. A recognised contributory factor is the increase in patient vulnerability. It was found that there was an intersection of reporting where some of the community reports (care homes) came from the MHLD division and alternatively some MHLD Reports came from secondary care.

2.11 Adults at Risk – Performance and Activity overarching for MHLD

2.11.1 In 2019-20 there were 525 adult at risk reports raised directly from the MHLD Division, as noted this equates to 43% of all BCUHB Adult at Risk Reports. Older People Mental Health (OPMH) equates to 19% of all Safeguarding activity and 44% of all the MHLD Safeguarding activity.

2.11.2 Table 6 identifies a 48% increase in the number of Adult at Risk Reports from the MHLD Division in comparison to 2018 – 2019. There is an increase in reporting within each individual area and regional services. Increased training activities and learning from desktop reviews may have supported an increase in awareness and reporting.

Table 6

MH/LD Reports	West	Central	East	Forensics	Rehab	Learning Disability	Total
2018-29	146	81	89	6	6	27	355
2019-20	159	125	154	9	12	66	525
Year on Year % Increase	↑ 9%	↑ 54%	↑ 73%	↑ 50%	↑ 100%	↑ 144%	↑ 48%

2.12 Learning Disability, Forensic, Rehabilitation and Commissioned Care all form part of the Regional Services within MHLD Division.

2.12.1 Learning Disability - Adult at Risk

There has been 66 Learning Disability adult at risk reports with the highest activity seen within Q3 as identified in Table 9. The considerable increase from 27 reports in 2018-19 was as a result of engagement and a revision of process in collaboration with Head of Learning Disabilities Nursing.

2.13 Rehabilitation - Adult at Risk

There have been twelve (12) adult at risk reports highest being within Q4. The majority of the reports are from 25-39 age group category.

2.14 Age groups - Adult at Risk.

In summary, the reports in relation to patients, aged 60+ are notably higher and this relates to increased vulnerability within this age range. 57% of all MHLD Adult at Risk reports in 2019-20 are from 60+ year olds, which is comparable to 55% in 2018-19. However, within Forensic and Rehabilitation the majority of the reports are from 25-39 age group category.

2.15 Categories of Abuse

62% of all MHLD reports in 2019-20 were alleged physical abuse. With the exception of sexual abuse, which has remained the same, all other categories of abuse have increased in comparison to 2018-2019. This is reflected in the overarching Safeguarding data.

2.15.1 The alleged perpetrator within Adult at Risk Reports, 84% of the physical abuse reports state another patient caused the harm, 87% of these reports are from the inpatient MH units. 325 of all reports record the 'other patient' as the alleged perpetrator in 2019-20, compared with 326 during the period of 2018-19.

2.15.2 Three (3) desktop reviews have taken place across the MHLD division to support patient on patient physical abuse and falls activity as detailed in Section 3.4.

2.16 The Deprivation of Liberty Safeguards (DoLS)

This was introduced in April 2009. The safeguards are an amendment to the Mental Capacity Act 2005. DoLS is supported by the Mental Capacity Act Code of Practice 2005

2.17 DoLS - Applications

In 2019-20, BCUHB received a total of 1014 DoLS applications. This is a 36% increase in applications in 2019-20 to those received in 2018-19 as seen in Table 7.

Table 7

Year	West	Central	East	England	Applications
2018-19	89	257	343	55	744
2019-20	177	282	483	72	1014

2.17.1 There are currently five Best Interest Assessors (BIAs) within the DoLS Team who are responsible for undertaking 4 out of the 6 assessments required under the DoLS legal framework.

2.17.2 On average, BIA assessments take between 1-2 days to fully complete, which is in line with the National picture.

2.17.3 The East Area reported 483 applications with 131 assessments conducted by a BIA compared to the West Area which reported 177 applications with 75 assessments conducted by the BIA

2.17.4 Some of the reasons behind the applications being withdrawn are:

- Patient regained capacity,
- Patient transferred from one hospital ward to a different hospital ward,
- Patient discharged from the hospital or moved to a care home,
- Died before authorisation,
- Ferreira - Ferreira (2017) case law prescribes that if patient is end of life care, then does not meet the 'Acid Test' element of 'not free to leave' and so does not meet DoLS criteria – this is a clinical decision.
- Patient subject to Mental Health Act 1983

2.18 Mental Capacity Assessment

2.18.1 The DoLS Team have been working with members of the Consent and Capacity Strategy Group to develop a new mental capacity assessment that is considered 'gold standard'. This is now operational and approved through the Office of the Medical Director.

2.18.2 This document will substantially support decision makers to evidence decisions in light of court and legal challenge in relation to an individual who lacks capacity. The work to embed the document into practice will continue to be a core element in DoLS training to staff.

2.19 Liberty Protection Safeguards (LPS)

2.19.1 The law relating to the Mental Capacity Act 2005 changed in May 2019 and is now referred to as the Mental Capacity (Amendment) Act 2019. This new Act will change the Mental Capacity Act Code of Practice and DoLS to create new statutory regulations known as Liberty Protection Safeguards (LPS).

2.19.2 A new Code of Practice and regulations to accompany the Act have yet to be published.

2.19.3 The impact of LPS is highlighted as a key safeguarding priority. It is known that the legislative changes will have significant implications in terms of demand, capacity, training, financial resources and challenges for the Health Board. Work-stream tasks groups will need to be put in place during 2020/21 to develop a strategic impact risk assessment and actions to mitigate against these risks and ensure successful Health Board implementation of LPS.

2.20 Court of Protection (CoP)

2.20.1 The details relating to Court of Protection cases and court hearings is detailed in Table 8. The number of cases referred by the DoLS service through BCUHB Legal and Risk Services has increased significantly from one (1) case in 2018/19 to 16 cases in 2019/20

2.20.2.All cases incur legal costs for which there is no allocated Safeguarding/DoLS budget. It remains a recognized cost pressure.

Table 8

	Number of individual DoLS cases referred to the Court of Protection	Number of Hearings in the Court of Protection
TOTAL	16	24

2.20.3 *Case Law* 16-17yr olds: *D (a child) [*2019] UKSC42

In September 2019, the Supreme Court held that in the case of *D v Birmingham*, where a 16 or 17 year old child cannot (or does not) give their own consent to circumstances satisfying the 'acid test' in *Cheshire West*, "parental responsibility for a child aged 16 to 17yrs of age does not extend to authorising the confinement of a child in circumstances which would otherwise amount to a deprivation of liberty" (Lady Black).

2.20.4 This judgement has impact for all Children's Services and CAMHS services across the Health Board. This was reported to QSG in November 2019.

2.20.5 Several actions were put in place, which included, amending DoLS mandatory training from December 2019.In collaboration with the Safeguarding Team – Children, direct training was offered to children's' services, CAMHS, and identified key health stakeholders involved in the provision of services to 16/17 year olds. A working task group is set to address changes in practice.

3. Safe Care

3.1 Rationale

3.1.1 All organisations must have a safe recruitment process that takes into account the risks to children and vulnerable adults.

3.1.2 There should be a system by which safeguarding concerns about employees should be raised and addressed. Departments and professionals delivering services must take full consideration of their safeguarding responsibilities.

3.2 Safeguarding People living with Dementia

3.2.1 The Head of Safeguarding for Adults MHLD attends the dementia Clinical Strategy Group and is fully engaged with the implementation of identified key priorities.

3.2.2 Corporate Safeguarding introduced the role of the Dementia Specialist for Safeguarding to strengthen the dementia strategy and safeguarding structure. The Safeguarding Dementia Specialist post is currently vacant and its recruitment is a key priority for 2020-2021.

3.3 The Sexual Safety - Task Group

The MHLD Division have co-produced a service user led policy that offers guidance to staff and patients when an individual is admitted onto a Mental Health ward in relation to sexual safety. Consultation sessions took place across North Wales between BCUHB staff, partner agencies, third sector agencies and service users. This has now been submitted for final approval.

Priority Action – 7

To support on the implementation of a multiagency co-produced MHLD guidance for patients and staff specific to Sexual Safety.	March 2021

3.4 Older People Mental Health (OPMH) Desktop Reviews

3.4.1 Following an increase in Adult at Risk reports, Corporate Safeguarding have supported 3 desktop reviews across different OPMH wards/ Unit, which focused upon safeguarding practices and to gain assurance on patient, staff and organisational safety.

3.4.2 The learning was:

- The first review generated an improvement plan relating to safeguarding processes and safe quality delivery of care
- The second review was undertaken due to the number of adult at risk reports submitted within a short timeframe. The findings of this audit were positive. In all cases, there was evidence to suggest that the staff had acted appropriately to safeguard individuals with good quality reporting and associated documentation.
- The third review held was in response to both safeguarding activity and the number of reported falls. The desktop review triangulated safeguarding data, Datix, governance and staffing. As a result, patients were made safe immediately and an OPMH improvement plan was developed.

3.5 Commissioned Care

3.5.1 Corporate Safeguarding support the MHLD Division with safeguarding concerns raised in relation to Commissioned Care Homes, Independent Hospitals, and Out of Area placements that include Forensic low and medium secure units.

3.5.2 During 2019-2020 Corporate Safeguarding have supported the MHLD division by working in partnership with the Independent sector, other commissioners, HIW, Police and local authorities to ensure residents are safeguarded and staff are safe in their practice.

Priority Action - 3

Increased engagement with BUCHB contract and commissioning services to review the safeguarding standards, policies and procedures of external care providers	March 2021

4. ACE Informed

4.1 Rationale

4.1.1 Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental illness are known to have a direct and immediate effect on a child's health. The safety of the child and the safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations**.**

4.1.2 During all health assessment activities the wider family must be considered to determine risk and harm and the impact this has on others. This is captured and reinforced in training, care planning and risk assessments.

5. Learning Culture

5.1 Rationale

By promoting, a positive culture of multi-agency learning to generate new learning organisations can support continuous improvements in service delivery and practice. Feedback from patients and clients in the NHS must be used to monitor and improve the quality of services.

5.2 Adult Safeguarding Training

5.2.1 Safeguarding training compliance is a key target for Corporate Safeguarding. A reduction in compliance is reported from February to date. It is recognised that no face to face training is taking place due to COViD 19 restrictions. Training continues to be available on e-learning and is supported by a revised virtual program to encourage ongoing training during this period.

Table 9

Compliance in Feb-20	West	Central	East
MCA – Level 1	86.1% ↑	82.5% ↑	83.4% ↑
MCA – Level 2	86.3% ↑	85.2% ↑	85.1% ↑
Safeguarding Adults – Level 1	80.1% ↑	76.7% ↓	78.3% ↔
Safeguarding Adults – Level 2	76.0% ↓	72.9% ↓	77.8% ↓

5.2.2 Table 10 represents Emergency Department's (ED's) safeguarding training compliance across BCUHB. In 2018-2019 Corporate Safeguarding recognised the challenges faced by ED's across BCUHB and have since looked to implement further training packages to support compliance. Medical staff compliance remains an area of challenge and it is recognised reporting processes may have affected the compliance data.

5.2.3 The increase in nursing staff compliance should be noted as a success over the last 12 months. The introduction of the development video-based learning will benefit this activity.

Table 10

February 2020	Staff	MCA L1	MCA L2	Adults L1	Adults L2
YG Medical Staff	44	26.8%	24.4%	29.3%	34.1%
YG Nursing Staff	95	95.6%	94.3%	86.7%	80.0%
YGC Medical Staff	57	50.0%	44.2%	44.2%	40.4%
YGC Nursing Staff	75	92.9%	92.9%	75.7%	74.3%
WMH Medical Staff	38	43.2%	43.2%	40.5%	37.8%
WMH Nursing Staff	104	91.1%	86.1%	77.2%	66.7%

5.4 Safeguarding Training

There have been 112 face-to-face safeguarding training sessions delivered across all three areas, resulting in 4,895 staff receiving training during 2019-20. Safeguarding Ambassador Training sessions have also been completed. Ambassadors are recruited to promote the safeguarding agenda across their own specialist area.

5.5 MHLD Training Compliance

5.5.1 Table 11 highlights the most up to date training data compliance available. With exception of Safeguarding Adults Level 2, training (84.1%) and Safeguarding Children Level 2 training (84.3%) the MHLD Division have achieved the organisational target of 85%.

Table 11

February Compliance	Staff	MCA – Level 1	MCA – Level 2	Adults – Level 1	Adults – Level 2	Children – Level 1	Children – Level 2	VAWDASV
MHLD	2049	93.2%	93.5%	86.1%	84.1%	87.1%	84.3%	85.3%

5.5.2 Corporate Safeguarding have worked collaboratively with the MHLD Division to implement an educational and training package to increase training compliance, as a result of Recommendation 4 of the HASCAS Report

5.5.3 In addition to the Mandatory Training, Corporate safeguarding have provided bespoke Level 3 Adult Safeguarding training in each area as a result of the desktop reviews within the OPMH Units and Wards.

5.5.4 These training sessions are based upon the findings and learning, relating to process, patient on patient physical abuse, quality of Adult at Risk Reports and professional accountability.

5.5.5 The triangulation of data and activities has resulted in the development a blended learning approach to enhance evidence of learning in practice. This will be delivered by skype, power point, presentation films and voiceover assessments. This will commence across the division from August 2020 and will use clinical staff as the voiceover to increase ownership.

Priority Action - 6

Implement the revised Level 3 MHLD training programme to obtain a minimum 85% target; this is to include the ICAN volunteers.	March 2021

5.4 DoLS Training

5.4.1 This has been created by increasing the range of training provision across BCUHB to include both internal and external health and social care professionals. This is evidenced in the Table 12.

Table 12

DoLS Training	Q1	Q2	Q3	Q4	TOTAL
TOTAL	129	169	288	34	620

5.4.2 Corporate Safeguarding have developed and implemented a governance framework to identify and support newly appointed DoLS authorisers (signatories), this was the first in the NHS in Wales.

5.4.3 During the past year, there has been successful recruitment resulting in the increased number of authorisers (signatories) trained and approved to carry out the governance role and function of DoLS assessments. Forty Nine (49) staff have accessed this training.

5.4.4 The MHLD division and East Area require a targeted approach as only four (4) and 8 staff accessed this training, compared to 19 in the West Area and 18 Central Area.

5.5 Welsh Government Grant

5.5.1 In March 2020, Corporate Safeguarding successfully obtained a Welsh Government grant to complete an external review of the Deprivation of Liberty Safeguarding assessment forms. We required assurance as a result of learning from the Court of Protection cases; the aim is to ensure documentation meets the legal challenge and requirements.

5.5.2 Training developed by a leading Barrister in preparation for the implementation of Liberty Protection Safeguards has also been commissioned using this funding. This will enable BCUHB to be fully prepared for the implementation of Liberty Protection Safeguards. This is a key priority during 2020/21.

Priority Action 9 & 10

9. The DoLS Forms created by W.Gov in 2015 and used by BCUHB are found to be inaccurate or legally deficient which can lead to a legal challenge so need revising	October 2020
10.Need to enable all registrants to have an induction on the impact and implementation of LPS, which replaces DoLS by 2021.	November 2020

5.6 Practice Development & Training Task Group

5.6.1 All BCUHB safeguarding training packages have been reviewed and updated to reflect and support the health board's policies and procedures and the wider safeguarding agenda.

5.6.2 Safeguarding training compliance is monitored by this group and escalated through the Safeguarding Reporting Framework. It facilitates learning from all Adult and Child Practice Reviews, local, regional and national inquires, new legislation and evidence-based practice.

5.7 Adult Practice Reviews (APR)

5.7.1 The purpose of Adult Practice and Domestic Homicide reviews is to clearly identify multi-agency learning for future practice.

5.7.2 The monitoring of the learning is by the Safeguarding Adult Board and internally by BCUHB Safeguarding Forums. The key themes and learning from the APR's and DHR's (Tables 20 and 21) over the last 12 months are summarised as:

- Poor communication across agencies
- Organisational compliance of training
- The quality of Record Keeping and Documentation
- Revision of current processes and protocols

Table 20

	2018-19	2019-20	Trajectory
APR	1	3	⇧

Domestic Homicide Reviews (DHR)

Table 21

	2018-19	2019-20	Trajectory
DHR	6	3	⇩

5.8 Outcome and Learning

5.8.1 All Adult Practice Reviews and Domestic Homicide Reviews are a standing agenda for monitoring at MHLD Divisional Governance meetings and the Safeguarding Forum.

5.8.2 The Home Office, have made amendments to the National PREVENT training standards. PREVENT training within BCUHB has been updated to ensure staff are competent in the management of any patients who may manifest radicalisation thoughts during clinical assessments.

5.8.3 To gain additional assurance Corporate Safeguarding have developed an action plan to bench mark recommendations from high profile Regional and National Safeguarding Reviews and investigations. The implementation of this work is a key priority for 2020-2021 and will offer further assurance that lessons learnt have been adapted into practice by the health board.

Priority Action - 5

Bench Mark recommendations from National/Regional Adult Safeguarding Reviews and investigations.	March 2021

6. Multiagency Partnership Working

6.1 Rationale

The protection and safeguarding of adults and children relies on multi-agency working and effective information sharing to improve services and outcomes for all.

6.2 PREVENT

6.2.1 The Associate Director of Safeguarding attends the CONTEST Board on behalf of BCUHB. Corporate Safeguarding attend the All Wales PREVENT meetings for regular updates from the Welsh Extremism and Counter Terrorism Unit (WECTU). Work is being developed with the Vulnerability Support Hubs in the UK; an identified priority for 2020-2021 is for key engagement at the All Wales Group. BCUHB have 100% attendance.

6.3 County Lines and the Harm Agenda

Over the last six months Corporate Safeguarding, on behalf of BCUHB, have been engaged with North Wales Police (NWP) to support their work in relation to a North Wales County Lines Needs Assessment. This is an increasing agenda for all agencies and BCUHB are a key partner agency. In early 2020, the Serious Violence and Organised Crime Board had commissioned a Task and Finish Group to review the multi-agency approach. This activity is paused due to the outbreak of the COVID-19 pandemic.

6.4 Modern Day Slavery

6.4.1 The Regional Modern Day Slavery Group has developed an improvement Action Plan

6.4.2 The All Wales Anti-Slavery Coordinator has stated that *"The hard work of the North Wales Group is now paying off by identifying more victims, to rescue and support them and where possible bring their perpetrators to justice".* Corporate Safeguarding are fully engaged in this work.

6.5 Multi Agency Public Protection Arrangements (MAPPA)

MAPPA are the statutory arrangements for managing sexual and violent offenders. Corporate Safeguarding representatives and Mental Health contribute to the identification and assessment of risk and agreed multi-agency risk management plan. Attendance at MAPPA is mandatory and Corporate Safeguarding have a 100% attendance rate, MHLD have a reported improved attendance and engagement.

Priority Action - 2

Benchmark and implement the County Lines Needs Assessment.	March 2021

6.6 Advocacy

6.6.1 Corporate Safeguarding engage and liaise directly with advocacy services across North Wales to ensure the patients individual rights are upheld. The offer of advocacy is now a legal requirement and is embedded into law.

6.6.2 A priority for 2020-2021 is to engage and support commissioning services to review the contract for the advocacy service.

Priority Action - 24

Engage and support the review of contracts for Advocacy Services.	September 2020

6.7 Partnership Working

6.7.1 In highly complex cases there has been inter-agency working between BCUHB and other key partnership organisations, these include the North Wales Fire Service, North Wales Police, Local Authorities, Third Sector agencies and Independent providers. The ethos of the Safeguarding agenda dictates the need for good partnership working, the importance of information and intelligence sharing at an early stage can support an immediate reduction in abuse or neglect.

7. Risk Management and the Corporate Risk Register

7.1.1 Corporate Safeguarding currently record that there is a risk that the Health Board does 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], the wider harm agenda and the Deprivation of Liberty Safeguards [DoLS]

7.1.2 This risk may be caused due to the failure to develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of safeguarding activity.

7.1.3 The current risk rating is recorded as 16 (extreme) with a target reduction noted as 12 (high)

7.1.4 The change in the risk reduction has not yet been achieved. This is a direct result of the challenge posed by the COViD-19 pandemic and following the National Welsh Government guidance relating to social distancing and face to face contact. As an immediate response, corporate safeguarding have introduced more flexible working and training methods to support the health board.

7.1.5 The risk in relation to DoLS is due to the the current level of activity, and the impact of LPS. It is known that the legislative changes will have significant implications in terms of demand, capacity, training, financial resources and challenges for the Health Board. The risks are also referenced on the risk register referencing an individual risk rating.

Priority Action - 11

Strategy Impact Risk Assessment developed to consider risk and mitigation against the demand and implementation of LPS across Health Board	April 2020

8. Conclusion

8.1 This report provides an overview of the ongoing Safeguarding activity, development and implementation of improvement plans to safeguard the patients, staff and organisation as a whole.

8.2 Trajectory of compliance and identification of performance data within 2019-2020 have shown continuous improvement against safeguarding 2018-2019 priorities.

8.3 In November 2019 Corporate Safeguarding presented a business case to the Quality Safety Group with an update and position in relation to the HASCAS 8 recommendation relating to the Corporate Teams staff resource due to the increased demands and the implementation of new legislation.

8.4 It is envisaged the proposed structure would provide additional assurance against specialist strategic, operational and administrative activities.

8.4.1 This is based upon the recognised activity data, and reported risks relating to the Deprivation of Liberty Safeguards and increased high risk and complex activities within the MHLD Division.

8.5 The report highlights identified priority activities for 2020-2021 to ensure full organisational engagement, ensuring BCUHB continue to strive, to fully implement the changing and challenging face of safeguarding across these priority areas.

Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

1. Introduction

1.1 Safeguarding and protecting people at risk and their families' forms part of everybody's responsibility. Employees of BCUHB, commissioned services, providers and contractors must engage, support and recognise their duty to report with the ultimate aim of promoting well-being, to reduce risk and ultimately harm.

1.2 This Annual Report 2019-2020 provides an overview of progress made by the Corporate Safeguarding Team in relation to safeguarding children at risk, safeguarding midwifery and the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) agenda.

1.3 It also sets out the strategic priorities, for these three areas, strategically driven by the Corporate Safeguarding Team for 2020-2021, demonstrating their commitment to continual improvement.

2. Governance and Rights Based Approach

Rationale

2.1 There should be a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of children. The UNCRC states that children should be free from abuse, victimisation and exploitation. The environments where children are treated should be safe, secure and child friendly.

Safeguarding Children at Risk

2.2 Internal Audit Report 2019/20

2.2.1 An internal review covering the period of 2017/18 took place. A detailed review of service delivery against the requirements of the Health and Care Standards, Safeguarding legislation and guidance. The result being Limited assurance.

2.2.2 A Follow-up internal review of the period of 2019-2020 found Substantial Assurance. No recommendations were made following this audit as reported findings had evidenced significant improvements had been made.

2.3 Safeguarding Maturity Matrix (SMM)

2.3.1 The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of capturing and collating a national SMM providing assurance, shared practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding across Wales.

2.3.2 The Safeguarding Maturity Matrix (SMM) has been piloted across all Health Boards/Trusts in Wales for the past two years. It has been agreed the self-assessment of safeguarding arrangements will continue for a third year, 2020-2021.

2.3.3 In November 2019, a Peer Review of all Health Board/Trusts scores took place. The five standards assessed were Governance and Rights Based Approach, Safe Care, ACE Informed, Learning Culture and Multi Agency Partnership Working. The highest achievable score is five (5) for each standard giving a total of twenty-five (25).

2.3.4 BCUHB achieved a score of 14 in 2018, and a score of 23 in 2019. This demonstrates excellent progress, and is the highest score in Wales.

2.3.5 An Improvement Plan has been developed and is being monitored by the Corporate Safeguarding Team. Annual feedback on the progress of the Improvement Plan is communicated to the National Safeguarding Team PHW and Chief Nursing Officer.

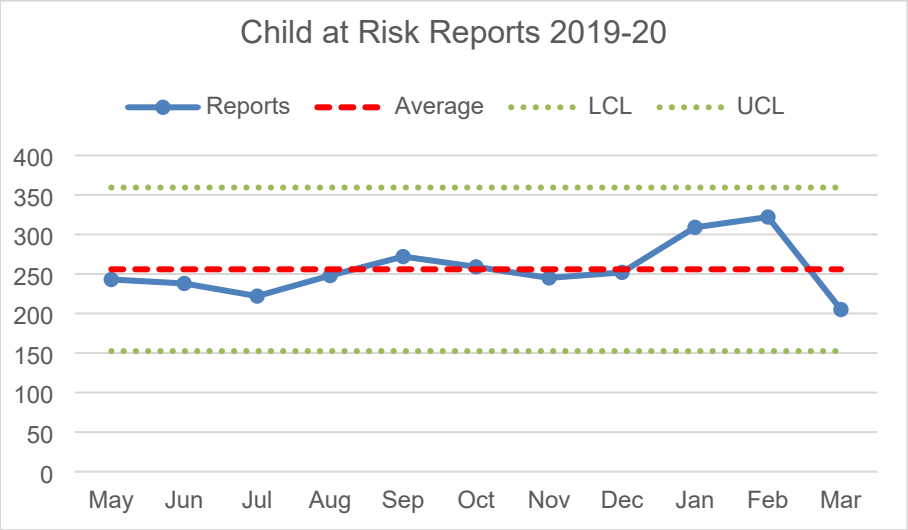
2.4 Children at Risk – Performance Reporting

2.4.1 Child at Risk Report Inboxes were developed and implemented in May 2019. This is a new process and mirrors that of the Adult at Risk process. It has provided rich data to provide further analysis and identify areas of good practice and areas requiring further improvements, in relation to the quality of completion.

2.4.2 In 2019-20 (from May 2019), there has been 2815 child at risk reports to the Local Authority; this averages to around 256 reports a month. The reports are generated by Health practitioners,

2.4.3 Figure 1 identifies the number of child at risk reports by month from May 2019 to the end of March 2020. The graphs are reported with a lower and upper control limits and median line to provide an overview of any trends.

Fig.1 – Number of Child at Risk Reports



2.4.4 The number of reports peaked in January and February 2020 due to a higher than average number of child at risks reports being received from health professionals in Gwynedd and both Flintshire and Wrexham Local Authority areas. The Corporate Safeguarding Team received a reduction in the number of reports in March 2020.

2.4.5 Almost half the reports to date are generated from the East area (n=1365, 48%). This demonstrates an increase rate of activity in the Local Authority geographical area of East compared to the Central and West areas.

2.5 Reports by Location and Referrer Designation

2.5.1 The number of reports being received from the community and those from acute settings are very comparable. For 2019-20, the number of reports from the community total to 1417 and those from the acute sites total to 1381.

2.5.2 The highest referrers to children's safeguarding in 2019-20 were:

- Emergency Department – 982 reports – 35%
- Health Visitors – 486 reports – 17%
- Midwives – 479 reports – 17%
- CAMHS – 283 reports – 10%

2.5.3 This data demonstrates the rationale for the reduction in Child at Risk Reports, during the COVID-19 pandemic, as there were fewer children being seen in the Emergency Department during this time and less face-to-face contacts were being carried out by midwives, health visitors, and school nurses.

Table 1 – Child at Risk Reports by Area and Quarters.

Reports by Quarter	Q1 (May-Jun)	Q2	Q3	Q4	Total
West	52	135	163	156	506
Central	194	227	243	258	922
East	233	376	340	416	1365
Out of Area	2	4	10	6	22
Total	481	742	756	836	2815

2.5.4 There has been an overall increase in the number of reports from Q1 to Q4. This may be as a result of an increase in child at risk activity or as a result of increased awareness due to the implementation of a new governance process.

2.5.5 The age group with the highest number of reports is the under-five age group where each area saw the most reports coming from this age group. A third of the reporting total are in this age group alone (33%).

2.5.6 On analysing the age groups by area, 52% of the unborn reports are from Central alone and 60% of the 11-15 age group reports are from the East alone.

2.5.7 If we analyse further, across all age groups, West appears static in Child at Risk Reports, whereas in Central safeguarding activity is greatest in the ages from unborn to the age of 10years and in the East, the Reports peak at age 5 years and again at 15 years.

This data gives the Corporate Safeguarding Team an opportunity to review resources, in respect to demand, around the safeguarding children at risk agenda.

2.6 Reason for generating a Child at Risk Report

More than three quarters of the reports (77%) in 2019-20 were made due to Child Protection concerns followed by 19% for Care and Support and 4% have been for Early Help.

2.7 Themes of Abuse

The data suggests that the highest number of reports fall under the category of neglect followed by emotional abuse.

Priority Activity 1a & b – Children at Risk

a) Full implementation of the Child at Risk Performance Reporting to include outcomes of the Report and themes of abuse	August 2020
b) To produce quarterly Child at Risk Performance Reports which are shared at the relevant forums holding Divisions to account.	July 2020

2.8 Section 47 Child Protection (CP) Medical Examinations

2.8.1 Community paediatricians continue to be available every weekday, on a rota system for Section 47 CP medical examinations at the request of North Wales Police or Social Services. These take place across BCUHB in each of the three areas.

2.8.2 For 2019-20 there have been 273 examinations carried out across BCUHB. More than three quarters of these were referred to BCUHB by social services (n=220 - 81%).

2.8.3 The highest number of examinations have been for children who live in the East (Wrexham and Flintshire).

2.8.4 Examinations for alleged physical abuse are the highest. Nearly half of these are for children in the under 5 year's age group (n=91 – 46%)

2.8.5 Forensic sexual abuse examinations are undertaken by six Community Paediatricians who provide a 24 hour, 7 days a week service across North Wales. This is recognised Nationally as best practice.

2.8.6 In 2019/2020 thirty five (35) forensic examinations took place out of hours and twenty five (25) within working hours.

2.9 Audit –Safeguarding Agencies Working Together in North Wales: Fact or Fantasy?

2.9.1 In 2019, a multi-agency survey was undertaken by a trainee paediatrician and supported by the Named Doctor Safeguarding Children.

2.9.2 The aim was to look at the way agencies 'work together' across North Wales, in relation to the Section 47 Child Protection Examinations. Agencies included were North Wales Police, social services, community and hospital paediatricians.

2.9.3 There were 166 respondents. These included 30 police, 99 social service employees, 13 community paediatricians and 24 hospital paediatricians.

2.9.4 Overall, the results show that individual agencies mostly rate their interaction with the other safeguarding agencies as satisfactory or better.

2.9.5 Recommendations included that paediatric trainees spend time shadowing police and social services colleagues as part of their community paediatric placement, creating a foundation of greater understanding and team working.

2.9.6 A training collaboration involving senior paediatric trainees attending children social services for a week was piloted. This was felt to be a highly successful collaboration.

2.9.7 The pilot will be extended over the forthcoming year. The results of the pilot will be presented to the Welsh Paediatric Society and once the data on the extended pilot has been evaluated, it is planned for this to be presented to the Royal College of Paediatrics and Child Health.

2.10 Child Protection Peer Review Meetings

2.10.1 Child Protection Peer Review Meetings are held bimonthly in each of the three areas. They are chaired by the Named or Assistant Named Doctors Safeguarding and are attended by hospital and community paediatricians. Cases of physical abuse, neglect and emotional abuse are presented. These are an excellent forum for sharing cases and respective learning.

2.10.2 Child Sexual Abuse Peer Review Meetings take place quarterly in the North Wales Sexual Abuse Referral Centre (SARC). They are attended by community paediatricians, SARC staff and a Consultant from Genito Urinary Medicine. Every case is discussed and the digital recordings captured by the video colposcope are viewed.

2.10.3 Viewing all of the cases enables community paediatricians to 'see' enough cases to enable them to maintain competencies and improve practice.

2.11 Safeguarding Supervision Sessions

2.11.1 In April 2019, BCUHB's Safeguarding Supervision Procedure was approved. The procedure forms part of BCUHB's statutory arrangements to ensure that safeguarding supervision, as appropriate, is embedded within the organisation and has clear evidence for improving the outcomes for children, adults and their families.

2.12 Safeguarding Supervision for School Nurses in Ruthin School

2.12.1 Due to high level safeguarding multi-agency concerns regarding Ruthin School, it was agreed for BCUHB to support the delivery of safeguarding supervision, to the three school nurses employed by the school.

2.12.2 A Service Level Agreement was developed between BCUHB and Ruthin School and this agreement was implemented on the 1st April 2020. Data and evaluation will be available for 2020-2021.

Priority Action 2 – Safeguarding Supervision Data

Full implementation of a standardised Regional Safeguarding Supervision Database to ensure the collection of consistent and meaningful data.	July 2020

3. ACE Informed

Rationale

3.1 Adverse Childhood Experiences (ACEs) such as exposure to domestic abuse, substance misuse and mental health illness are known to have a direct and immediate effect on a child's health.

3.2 The safety of the child and safety of the vulnerable adult are intrinsically linked; preventing early exposure can reduce the impact on children and future generations

3.3 Looked After Children (LAC)

The accountability and portfolio for the LAC Service sits within the Children's Division and outside of the Corporate Safeguarding Team. The Head of Safeguarding Children attends the quarterly LAC Team meetings to share up to date knowledge/good practice and learning regarding safeguarding. This ensure good two-way communication between both services.

3.4 Safeguarding Supervision data

The standard agreed for LAC Nurses is that they attend six monthly safeguarding supervision and have access to all group supervision sessions. Supervision Compliance Data 100%

3.5 LAC Statistics for 2019-2020

3.5.1 During this period, there have been a total of 1687 Looked After Children under the remit of Anglesey, Conwy, Denbighshire, Flintshire, Gwynedd and Wrexham Local Authorities. This is an overall increase of 4% upon the figure of 1616 during the same period in 2018-19.

3.5.2 Gwynedd saw an increase of 17%, Anglesey saw an increase of 5% and Wrexham saw an increase of 12% and all other LA saw a decrease.

3.5.3 Of those 1687, there were 245 whose placements ceased during the same period making a current total of 1442 as at 31 March 2020.

3.6 Health Assessment

3.6.1 The Social Services and Well-being (Wales) Act 2014 states that all children in care must have a health assessment. When children become "looked after", an initial health assessment must be undertaken within 28 days of the date that they became "looked after".

3.6.2 Thereafter, a review health assessment is undertaken every 6 months for children under the age of 5 years or annually for those aged 5 and over. School Nurses, Health Visitors, LAC Nurses or Paediatricians predominately carry these out.

Table 2 - Percentage completed by staff groups 2019-2020

2019-20 Review Health Assessments	Total %
HV	25%
SN	16%
LAC Nurse	48%
Paediatrician	11%
Total	100%

3.6.3 Table 2 demonstrates that the LAC Nurses carry out the greatest number of Review Health Assessments, with the exception of Gwynedd, Health Visitors carried out the majority of Review Health Assessments.

3.6.4 The total number of Review Health Assessments completed in 2019-2020 were 1371

3.7 Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE)

3.7.1 During 2019-2020, two CSE Operations were discontinued. There are no current CSE Operations being operated across North Wales.

3.7.2 In Section 6 of the new Wales Safeguarding Procedures are the All Wales Practice Guidance on Child Sexual Exploitation (CSE).

3.7.3 The new approach has been incorporated into the Level 3 CSE Training Package. Further awareness will be delivered to targeted areas such as Sexual Health and School Nursing.

3.7.4 Criminal Exploitation is also known as 'County Lines' and relates to gangs and organised crime networks who groom and exploit children and other vulnerable groups to sell drugs. Child Sexual Exploitation Panels are now referred to as Exploitation Panels to incorporate and consider the range of exploitation young people and their families might be a victim of. The Corporate Safeguarding Team provide full engagement to these Panels cross the region.

4. Learning Culture

Rationale
By promoting a positive culture of multi-agency learning to generate new learning organisations can support continuous improvements in service delivery and practice. Feedback in the NHS must be used to monitor and improve the quality of services.

4.1 Training

Table 3 – Training Data for Safeguarding Children Level 1 and 2

Safeguarding Module	April 2019	February 2020	Trajectory
Safeguarding Children – Level 1	79.1%	80.6%	⇧
Safeguarding Children – Level 2	78.4%	78.2%	⇩

4.1.1 The overall compliance for Safeguarding Children Level 1 has seen a positive trajectory however; Safeguarding Children Level 2 compliance has lowered. This may be as a result of the organisation putting face to face Mandatory Training on hold due to COViD 19.

4.2 Level 3 Safeguarding Children Level 3 Programme of Learning

4.2.1 Safeguarding Children at Risk Level 3 is co-ordinated via a 3-year training plan incorporating specific safeguarding topics identified from recommendations of child practice reviews and national reviews.

4.2.2 Due to COVID 19, face-to-face sessions of Child at Risk Level 3 was postponed in quarter 4. Corporate Safeguarding are developing an Interim COVID 19 package, delivered using a blended learning approach using power point voiceover, skype and assessment.

4.2.3 There were 37 Level 3 Safeguarding Children Training sessions with 1,659 attendees.

4.3 Child Practice Reviews (CPR)

4.3.1 During 2019-20 there have been no new cases commissioned by the Child Practice Review Sub Group. However, activities to support a Wrexham Multi Agency Professional Forum (MAPF), a Wrexham Concise Child Practice Review (CCPR), a Conwy CCPR and a Flintshire CCPR continues.

4.3.2 The Wrexham MAPF has been completed and presented at the Regional CPR Sub Group and Local Delivery Groups. The Wrexham CCPR is due for publication on the 17th June 2020 and the North Wales Safeguarding Children Board will monitor the Action Plan.

Table 4 – Regional CPR''s Annually 2017-2020

	2017-2018			2018-2019			2019-2020	
MAPF	ECPR	CCPR	MAPF	ECPR	CCPR	MAPF	ECPR	CCPR
0	1	0	0	2	1	1	0	3

4.4 Learning from Child Practice Reviews (CPR's)

Cardiff and Vale Child Practice Review

4.4.1 The Corporate Safeguarding Team provide BCUHB assurance against both Regional and National published Child Practice Reviews. A recommendation from the Cardiff and Vale CPR – "*The Accident and Emergency Department have weekly safeguarding meeting to consider head injuries and burns in children aged under one. This was extended to include fractures in children aged under two years old."*

4.4.2 This activity was piloted in the Emergency Department (ED) in YGC from February – April 2019 and fully evaluated in July 2019. The successes of the pilot included:

- Greater aware of safeguarding policies and procedures
- Increased engagement with the Safeguarding Team, both in person and by telephone
- Awareness of the escalation process when concerns are identified
- Increased quality of referrals being submitted, although these may not necessarily be relating to cases forming part of the weekly ED Safeguarding review process
- Assurance that YGC ED are complying with Recommendation 3 of the C&V CPR

4.4.3 The recommendation was to continue with the current activity in YGC ED and to extend the activity to the East and West ED's. A regional audit will take place and will be evaluated in July 2020 and in January 2021.

4.5 Trauma Risk Management (TRiM)

4.5.1 The Flintshire Extended Child Practice Review, published in July 2019, made a recommendation for all agencies to develop a Safeguarding Critical Debrief Model. This was as a result of practitioners, including health, expressing concerns of the lack of support following a traumatic event, such as the unexpected death of a child.

4.5.2 In August 2019, the Head of Safeguarding Children developed a TRiM Business Proposal, funding was secured for the training of sixteen staff from the Corporate Safeguarding Team to be TRiM Practitioners and for four of the sixteen to be TRiM Managers. The Head of Safeguarding Children adopted the role of TRiM Coordinator. The training took place in November 2019 and was delivered *by 'March on Stress'.*

4.5.3 Trauma Risk Management (TRiM) is a peer-led process that seeks to identify and assess the psychological risk to individuals who have experienced trauma in the course of their work.

4.5.4 Early identification of staff exposed to trauma, aids to promote a healthy workforce by supporting the welfare needs of staff, and contributes towards reducing staff absence.

4.5.5 The TRiM process was launched on the 4th May 2020 and BCUHB is the first Health Board in Wales to invest in the TRiM process. Future investment will need to be considered to ensure the long-term sustainability of a much needed support service for staff.

4.6 Mid and West Wales Safeguarding Children Board Concise Child Practice Review

This report was published in early 2020. The Head of Safeguarding Children and the Specialist Safeguarding Midwives are leading on this activity. Immediate learning includes the development of a Level 3 Safeguarding Children – Learning Disability training package. A Task and Finish Group will be developed to coordinate this.

Priority Actions 3a, b & c – Child Practice Reviews

a) To complete the audit in relation to weekly safeguarding meetings in the three ED's, arising from the Cardiff and Vale CPR, and complete a full evaluation report and action plan	March 2021
b) To fully monitor and evaluate the TRiM Process across BCUHB and provide feedback to the North Wales Safeguarding Children Board	December 2020
c) To complete the BCUHB Action Plan in relation to the Mid and West Wales CPR and fully embed the learning into current practice	December 2020

4.7 Learning from BCUHB Serious Incident Reviews

Corporate Safeguarding provides expertise/advice as a panel member on Serious Incident Reviews involving children. This input gives assurance all aspects of safeguarding have been considered.

4.8 Review of Childhood Suicides

4.8.1 The Head of Safeguarding Children and the Named Doctor Safeguarding Children completed in September 2019, an observation report looking at childhood suicides in North Wales, from 2013-18.

4.8.2 Nine cases of childhood suicide were included. Findings included:

- Four were male (44%) and five were female (56%).
- Two children were aged 13 years, three were 15 years, two were 16 years and two were 17 years at the time of death.
- The highest proportion of this cohort resided in North East Wales (66%).
- Seven children (78%) died from hanging and two children (22%) died from jumping off a bridge. It was interesting to note that no children/young people in this cohort died due to self-poisoning (overdose).

4.8.3 The findings also demonstrated the link of significant psychosocial features in the family backgrounds, which are common risk factors in childhood suicide. Seven out of nine children (78%) had a history of self-harm.
Five out of the nine expressed concerns regarding bullying and in five cases a mental disorder was suspected. Adverse Childhood Experiences (ACE'S) also featured in seven of the cases although two children evidenced no history of ACE's.

4.8.4 Although this review was on a small scale and conclusions cannot be reached it gives a local picture around childhood suicides. This report has been presented at a number of Safeguarding and Children's Strategic Forums

4.9 A guide to responding to a single or a cluster of suicides in children and young people

The Head of Safeguarding Children was a member of the North Wales Suicide and Self-Harm Prevention Group – Steering Group in supporting the development of a community response to suspected death by suicide.

5. Multi Agency Partnership

Rationale
The protection and safeguarding of vulnerable adults relies on multi-agency working and effective information sharing; working together to improve services and outcomes for all.

5.1 Procedural Response to Unexplained Deaths in Childhood (PRUDiC).

5.1.1 The North Wales Safeguarding Children's Board provides the governance arrangements around the PRUDiC process within North Wales. All cases are monitored through the Regional Child Practice Review Sub Group.

5.1.2 The Head of Safeguarding Children is BCUHB's Single Point of Contact and coordinates and supports staff in this process.

5.1.3 The PRUDiC Standard Operating Procedure (SOP) has recently been reviewed, and strengthens communication and process with out of area hospitals, for those children who unexpectedly die outside of North Wales.

5.1.4 In 2019-20 there have been fourteen (14) PRUDiC's across BCUHB. Half of these (50%) have taken place in Central.

5.1.5 On looking at the themes of unexpected deaths in children for 2019-2020 there are no similar themes identified. Each unexpected death had its own explained cause but no trends/themes could be generated.

Table 5 – PRUDiC Cases – Annually 2016-2020

2016-17	2017-18	2018-19	2019-20
13	16	14	14

5.2 Child Death Overview Panels (CDOPs)

5.2.1 The CDOPs continue to take place across North Wales in each of the three areas. They are well attended by senior management from all agencies responsible for safeguarding children.

5.3 Mothers and newborn babies requiring 24-hour supervision on Maternity Units when safeguarding concerns have been identified.

5.3.1 When an unborn is deemed to be at risk of harm, Local Authorities cannot apply for an Interim Care Orders until the baby is born. The consequence of this is a delayed discharge.

5.3.2 The Standard Operational Procedure Safeguarding Children and Young People Discharge plan was ratified in August 2019.
This document ensures that all children and young people, where safeguarding concerns, have been identified, are safely discharged from hospital.

5.4 Multi- Agency Working with Partners

Multi-agency engagement is a statutory requirement of BCUHB. The Corporate Safeguarding Team have achieved 100% attendance at statutory Safeguarding Boards, and Sub Groups. The level of required engagement is high with the requirement of full participation and contribution to the Work Plan.

5.5 Under 18s assessed for Section 136 Assessments

5.5.1 The 136 suites are located within the Acute Mental Health Units but have designated areas. Under 18s are assessed under Section 136 of the MHA within these areas.

Table 6 – under 18's assessed under Section 136 April 2019 – March 2020

Area	Number	Age Range	Outcome
East	21	12-17 years	
Central	7	12-17 years	
West	10	14-17 years	
Total BCUHB	38		**4** Discharged – no mental disorder **8** Discharged – referred to services **16** Discharged – follow up services **9** Admitted **1** Section Lapsed

5.5.2 The numbers of under 18's assessed under Section 136 has increased considerably compared to 25 in 2018-19. The increase is primarily in the East from 13 to 21. This data could be linked with the findings of the Childhood Suicide Report as 66% of the children in that cohort resided in the East.

5.5.3 Corporate Safeguarding are developing a practitioner led IT based learning tool to support the promotion of escalation, engagement and care planning.

5.6 Deprivation of Liberty (DoL) 16/17 year old

5.6.1 In 2019, new case law was introduced which stated that "parental responsibility for a child aged 16 to 17yrs of age does not extend to authorising confinement of a child in circumstances which would otherwise amount to a deprivation of liberty."

5.6.2 In essence, a parent cannot consent to the young person being deprived of their liberty if a young person lacks capacity. If DoL applies then an application must be made to the Court of Protection.

5.6.3 This is a change in practice for BCUHB staff. Information has been shared through the Safeguarding Bulletin, Safeguarding Level 3 Children Training has been updated, information has been shared during Children's and in a number of Safeguarding Forums.

6. Learning Culture

Safeguarding Midwifery

6.1 Health Pre Birth Assessment

6.1.1 In 2018-19 an audit undertaken by the North Wales Safeguarding Children Board, together with the learning from a Child Practice Review, identified that a review of the Health Pre-Birth Assessment (HPBA) was required. In May 2019, the Guidance for Completion of the Health Pre-Birth Assessment by Midwife/Health Visitor was ratified.

6.1.2 To provide the Health Board with assurance regarding compliance, an audit was commenced in April 2019 – March 2020, identifying areas for improvement.

Table 7 – Findings from the HPBA Audit 2019-2020

	Number of notes included in the audit	HPBA completed between 12-30 weeks of pregnancy	Good quality HPBA (legible/completed in entirety/clear rationale for any gaps)	Written consent for completion and information sharing	HPBA populated with name and ID number	Signed by both MW & HV	Evidence of Review	Evidence of HPBA shared with LA
BCU	108	92 (85%)	90 (83%)	72 (67%)	44 (41%)	81 (75%)	32 (30%)	55 (51%)

6.1.3 A joint Action Plan 2020-2021 will be developed with Women's, Children's and Safeguarding to include the main recommendations for improvement.

6.1.4 The audit was presented at the Women's Divisional Group, Safeguarding Leads meeting and disseminated to the Assistant Area Directors Children's, supported by a guidance memo.

Priority Action 4a & b – Health Pre- Birth Assessment Audits (HPBA)

a) To undertake the HPBA Audit for 2020-2021 to provide assurance of improvement and compliance.	April 2021
b) To develop an Action Plan for the findings in the HPBA Audit 2019-2020 to provide assurance that the actions are monitored and completed	June 2020

6.2 Female Genital Mutilation (FGM)

6.2.1 Female Genital Mutilation (FGM) is a criminal offence as set out in the FGM (2003) in England, Wales and Northern Ireland. It is child abuse and a form of violence against women and girls, and therefore must be treated as such.

6.2.2. All health staff have a safeguarding obligation to identify the potential for and cases of FGM, in addition to the mandatory duty to report for regulated professionals in line with the Serious Crime Act (2015).

6.2.3 A Standard Operating Procedure Female Genital Mutilation was ratified in April 2019.

6.2.4 BCUHB provide quarterly reporting FGM data to Welsh Government.

Table 8 – FGM reports annual comparison 2016-2019

Year	2016-17	2017-18	2018-19	2019-20
Cases of FGM	6	6	5	5

6.2.5 Midwives identify most of the FGM cases reported. In the Safeguarding Maturity Matrix Improvement Plan 2019-2020 it was agreed to develop wider training across BCUHB, in relation to FGM. This has subsequently commenced in the Sexual Abuse Referral Centre (SARC), for Practice Nurses, Cervical Cytology Screening Services, Sexual Health Services and Gynaecological Services.

6.3 Surrogacy

6.3.1 It is recognised within BCUHB that infants will be born that will be subject to a surrogacy agreement between birth/surrogate mother and the intended/commissioning parents/mother/father. It is important for all staff to be aware of the legal requirements in surrogacy cases.

6.3.2 In May 2019, the Surrogacy Procedure was reviewed and ratified providing all relevant staff with information and guidance in relation to surrogacy.

6.4 Infant Safer Sleeping Guidance

The Infant Safer Sleeping Guidance was reviewed and ratified in June 2019. The guidance has been produced in recognition of the fact that unsafe sleeping arrangements are a feature in the deaths of some infants in North Wales. The emphasis of the document is on promoting safer sleeping environments for infants.

6.5 Coping with Crying Guidance

6.5.1 Non-accidental Head Injury (NAHI) remains the most common cause of fatal maltreatment in infants. At least half of the infant survivors will have significant neurological impairment. Crying is considered as being a key trigger for NAHI.

6.5.2 The Coping with Crying Guidance has been reviewed and is currently under wider consultation. The Guidance aims to eliminate the incidence of NAHI by raising the awareness of parents and carers of the risks and consequences of shaking an infant.

6.5.3 Currently the Head of Safeguarding Children is in consultation with the NSPCC for BCUHB to receive an updated film and Education Package.

Priority Action 5 – Coping with Crying Guidance

To ensure ratification of the Coping with Crying Guidance and to receive from the NSPCC the updated film and training materials in order to improve practitioners knowledge	September 2020

6.6 Safeguarding Supervision

6.6.1 As part of the Safeguarding Maturity Matrix Improvement Plan 2019-2020 the Corporate Safeguarding Team agreed to extend the provision of formal safeguarding supervision to midwives and other health practitioners across the Health Board. In July 2019, it was agreed to offer the Women's Division group supervision sessions similar to the ones offered to Health Visitors and School Nurses.

6.6.2 Supervision is relevant to support midwives; the group supervision sessions provide an opportunity for learning/reflection and networking. Detailed data evidences that the Midwifery service in the Central area access the greatest number of supervision sessions, delivered using a variety of methods.

6.7 Midwifery Safeguarding Children Level 3 Training by Area and Quarter.

6.7.1 Safeguarding Specialist Midwives deliver Level 3 Safeguarding Children training for midwives in each area once a month.

6.7.2 March 2020 session was postponed due to COVID 19. Corporate Safeguarding has mitigated against this risk by producing an Interim COVID 19 Safeguarding Children Level 3 Midwifery training, by filming a power point presentation with voiceover and completion of an assessment.

7. Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV)

7.1 Routine Enquiry Domestic Abuse during Pregnancy

7.1.1 Audit of Routine Enquiry Domestic Abuse during Pregnancy 2019-2020

7.1.2 A further audit was conducted to obtain assurance due to areas of poor compliance in the audit of 2018-2019.

7.1.3 Concerns were raised following the Audit 2018-2019 regarding the number of women who were not asked (30%). This audit also did not report on the rationale for women not being asked and so this was included in the scope of the Audit 2019-2020.

Table 9 – Audit of Routine Enquiry Domestic Abuse during Pregnancy 2019-2020

2019-20	Audited Notes	Asked Once	Asked Twice or More	Not Asked	Not Asked - Accompanied	Not Asked - No Reason Given
West	180	69%	49%	31%	11%	20%
Central	180	71%	49%	29%	17%	12%
East	180	76%	44%	24%	18%	6%
BCUHB	540	72%	47%	28%	15%	13%

7.1.4 From 2018-2019 the findings demonstrate a slight improvement 70% - 72% in women being asked once, however, this shows there are still 28% of pregnant women still not being offered routine enquiry domestic abuse. The 2019-2020 data collated the reasons for this with 15% of pregnant women being accompanied by their partners as a reason and 12% no reason was given.

Priority Action 6a & b – Audit of Routine Enquiry Domestic Abuse during Pregnancy 2020-2021

a) To undertake the Routine Enquiry Domestic Abuse Audit for 2020-2021 to provide assurance of improvement and compliance	April 2021
b) To develop an Action Plan for the findings in the Routine Enquiry Domestic Abuse Audit 2019-2020 to provide assurance that the actions are monitored and completed	June 2020

7.2 Review of the All Wales Antenatal Routine Enquiry into Domestic Abuse within NHS Wales

7.2.1 As part of the NHS Wales Safeguarding Network Work Plan, the Head of Safeguarding Children BCUHB and a Designated Nurse National Safeguarding Team PHW, agreed to conduct a review of the All Wales Antenatal Routine Enquiry into Domestic Abuse within NHS Wales.

7.2.2 The audit aimed to establish whether midwives and health visitors are routinely asking women about domestic abuse and whether Health Boards are meeting the requirements within the All Wales Routine Minimum Standards (2009). As a result, the audit has clearly identified inconsistencies across the seven Health Boards relating to the current practice of routine enquiry.

7.2.3 Recommendations included:

- Health Boards need to ensure that Health Visitors and Midwives have robust communication and sharing information protocols to ensure relevant information related to routine enquiry is shared appropriately between them.

- The NHS Wales Safeguarding Network to revise the All Wales Minimum Standards in order to support the development of a consistent universal audit process of the routine enquiry.

- The NHS Wales Safeguarding Network to consider, in view of these findings, whether a further piece of work is warranted in view of why women are not being asked, which could support Health Boards in developing any improvement plans.

- For all Health Boards to develop improvement plans, in relation to monitoring compliance in asking once and subsequently twice, considering the exploration of different approaches.

- The VAWDASV Steering Group to monitor any changes to the All Wales Minimum Standards and consider in relation to existing Group 2 training.

The recommendations will be incorporated into the NHS Wales Safeguarding Network Work Plan for 2020-2021.

Priority Action 7 - Review of the All Wales Antenatal Routine Enquiry into Domestic Abuse within NHS Wales

To ensure Corporate Safeguarding fully engage in the NHS Wales Safeguarding Network Work Plan 2020-2020 in respect to the recommendations of this review.	March 2021

7.3 Multi Agency Risk Assessment Conferences (MARAC)

7.3.1 MARAC Referrals

High-risk victims of domestic abuse, identified by health professionals, are referred for discussion at a MARAC. These meetings are held in the six Local Authority Areas with key representation from BCUHB.

Table 10 – Number of MARAC Referrals Annual data 2018-2019 and 2019-2020

Year	Q1	Q2	Q3	Q4	Annual Total	Trajectory
18-19	53	30	55	33	171	↑
19-20	37	46	41	56	180	↑

7.3.2 On the 1st February 2020, BCUHB following discussion with North Wales Police and the All Wales Live Fear Free Helpline changed the MARAC Referral process. Health professionals forward the referral to a secure inbox directly to North Wales Police.

7.4 MARAC Virtual Meetings

7.4.1 The East Safeguarding Team supported a pilot for a weekly virtual MARAC (via Skype) for Flintshire Local Authority. The pilot commenced on the 11th February 2020 and completed on the 31st March 2020. This pilot was agreed as the numbers of high-risk victims of domestic abuse being discussed in a monthly MARAC, had increased to an unmanageable level, and agencies were committing all day resources to meet the demand.

7.4.2 On evaluating the pilot, the outcome was that high risk victims of domestic abuse were discussed by a multi-agency team in a timely manner with actions completed. This not only reduces the number of cases discussed during the monthly meeting but also reduces risk for the victim.

7.4.3 Due to the success of the Flintshire pilot, North Wales Police would like to implement this across North Wales. Wrexham MARAC have adopted this process from the 1st April 2020, with other Local Authorities aiming to engage.

7.5 BCUHB VAWDASV Procedures

7.5.1 Violence against Women, Domestic Abuse and Sexual Violence (VAWDASV) Workplace Procedure

7.5.2 BCUHB recognises that within its workforce there will be employees who have experienced, or who are currently experiencing domestic violence and abuse, as well as employees, who are perpetrators or alleged perpetrators.

7.5.3 The procedure was ratified in September 2019 and has been fully implemented across the Health Board

7.5.4 The development of Workplace Safety Groups across the region, acts as a specialist group to advise and support managers in ensuring the safety and well-being of staff, whilst also ensuring that procedures in relation to domestic violence and abuse are followed. This procedure supports the Workplace Safety Groups.

7.6 Violence against Women, Domestic Abuse and Sexual Violence Service User Procedure

7.6.1 BCUHB is committed to creating an environment which encourages disclosures of domestic abuse and sexual violence within the health care setting and workplace, and is committed to providing support and advice to all those affected.

7.6.2 This procedure was ratified in January 2020 and has been fully implemented across the Health Board. It identifies processes to support staff in the identification and management of domestic abuse and sexual violence.

7.7 Regional and National VAWDASV Groups

7.7.1 Regional Strategic VAWDASV Board

The Regional Strategic VAWDASV Board has continued to meet quarterly during 2019-2020 with 100% engagement from BCUHB. The Vice Chair is currently the Head of Safeguarding Children. The Commissioning and Training Sub Groups are also well attended by BCUHB with full engagement and participation.

7.8 National VAWDASV Steering Group

The National VAWDASV Steering Group is a Sub Group of the All Wales Safeguarding Network. The Group have continued to meet quarterly during 2019-2020 with 100% engagement from BCUHB. The focus of the group has been around Routine Enquiry Domestic Abuse and the G2 NHS Wales Package for VAWDASV.

7.9 Domestic Homicide Reviews (DHR)

7.9.1 A DHR is a multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom they were related or with whom they were, or had been, in an intimate personal relationship, or a member of the same household as themselves.

Table 11 - Number of DHR's 2018/2019 and 2019/2020

Year	Number of live DHRs	Number signed off	Number Ongoing
2018-2019	6	3	3
2019-2020	3	0	3

7.9.2 BCUHB are fully engaged with all the DHR's across North Wales. All learning is fully embedded across all service areas in BCUHB by the monitoring of the action plans.

7.10 Sexual Assault Referral Centre (SARC)

Amethyst is a Sexual Assault Referral Centre (SARC) for North Wales, where a range of specially trained professionals give help, support and information to individuals who have been raped or sexually assaulted, whether recently or in

the past. This service has been developed in partnership with the police, health and voluntary services to ensure that victims of crime get the best possible care.

7.11 Sharing Stories/Rhannu Straeon Project

7.11.1 The aim of the project in collaboration with SARC was to:

7.11.2 Inform children and young people about the Criminal Justice System (CJS) process support the recovery of young survivors by giving them a positive platform and an opportunity to reframe their trauma, increase their resilience and reduce isolation.

7.11.3 The project has been developed from work undertaken in Amethyst SARC's young women's group coordinated by the Children and Young Peoples Sexual Violence Advisor (CYPSVA). The group have developed a booklet based on their experiences and journeys, a film and podcast.

7.11.4 The project was nominated for the National Crime Beat Awards and was the winner of the Young Peoples Award.

7.12 Self-Aid Recovery Programme (SARP)

7.12.1 The project involves working collaboratively with Psychology colleagues and third sector partners to develop a psycho-educational group programme for adult survivors of sexual violence with post-traumatic stress.

7.12.2 Evaluation of this project has been delayed due to COVID-19 and is awaiting Welsh Government approval for an extension to the current deadline.

7.13 Wig and Gown

A CYPSVA was successful in achieving funding through PACT (Police and Community Team) to purchase a Wig and Gown as worn by barristers and judges in court. The aim of this is to familiarise children and young people with this clothing, explaining procedures and why this is worn, and helping to reduce the general anxiety around the court experience.

7.14 Agencies Domestic Abuse Perpetrator Tasking (ADAPT)

7.14.1 ADAPT is a multi-agency approach of working with repeat perpetrators of abuse. Those repeat perpetrators who refuse to engage with the programme will continue to be managed following pursue and disrupt tactics.

7.14.2 Six (6) ADAPT conferences where held in 2019/20 with BCUHB Corporate Safeguarding attending 100% of conferences. Sixteen (16) individual perpetrators have been discussed at conferences.

7.15 Positive Outcomes:

7.15.1 Good inter-agency working which has promoted good communication between North Wales Police, Local Authorities and the Probation Service.

7.15.2 There has been a reduction in domestic abuse re-offending by perpetrators discussed within ADAPT. At each ADAPT conference the police provide a summary of any further incidents relating to specific perpetrators.

7.16 Training Data - Violence against Women, Domestic Abuse & Domestic Violence (VAWDASV).

BCUHB VAWDASV training is in line with National Training Framework on Violence against Women, Domestic Abuse & Sexual Violence that provides guidance on statutory requirements for training across the public sector and specialist third sector. Training compliance has improved from 56.8% in 2018 – 2019 to 72.5% in 2019 – 2020.

8. Conclusion

8.1 Throughout the Annual Report 2019-2020, it is clearly reported that the level of safeguarding activity has greatly increased, in relation to safeguarding children and those affected by VAWDASV. This has prompted a robust response from the Corporate Safeguarding Team, in providing assurance, that the complexities and challenging safeguarding agenda is fully implemented.

8.2 The Annual Report 2019-2020 demonstrates significant improvements made within the Child at Risk agenda.

8.3 The identified improvements include the availability of Child at Risk Performance data, the improvements made within the Safeguarding Maturity Matrix in regards to the assurances in relation to BCUHB's safeguarding arrangements and in the learning activities captured to embed learning and improve practice.

8.4 Within the VAWDASV agenda, significant improvements are demonstrated on a local, regional and national picture, which required true multi-agency working and engagement.

8.5 The report highlights identified priority activities for 2020-2021 to ensure full organisational transparency, ensuring BCUHB continue to strive, to fully implement the changing and challenging face of safeguarding across these priority areas.

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	**Essential Services during Covid-19**
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Jill Newman Director of Performance
Craffu blaenorol: Prior Scrutiny:	Discussed on Planned Care Improvement Group
Atodiadau Appendices:	*2* *Appendix 1: Monitoring Tool* *Appendix 2: Summated Responses*

Argymhelliad / Recommendation:

The committee is asked to:

- note the content of this report
- recognise that the health board has taken steps to understand its ability to comply with essential services and in doing so has identified areas of particular challenge that need to be addressed as priority areas in the Q2 operational plan.
- note the need to continue to monitor, escalating as appropriate, compliance with revised Essential Services guidelines in order to mitigate the risk of harm.

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

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

Sefyllfa / Situation:

This paper provides an update on the delivery of Essential Services during the Covid-19 pandemic.

Cefndir / Background:

- Essential services are those services contained within the WG/NHS Wales “Framework for Maintaining Essential Health Services during the COVID-19 Pandemic”. This identifies as ‘essential services’ that should be maintained (or, where stopped, reinstated) in order to prevent avoidable mortality and significant (life impacting) morbidity from non-COVID causes and to ensure equity across Wales. This framework was developed by the Essential Services Cell of Welsh Government using the World Health Organisation ‘COVID-19: Operational guidance for maintaining essential health services during an outbreak’.
- .WHO advises that the following high-priority categories should be included as Essential Services:

- essential prevention and treatment services for communicable diseases, including immunizations;
- services related to reproductive health, including during pregnancy and childbirth;
- core services for vulnerable populations, such as infants and older adults;
- provision of medications, supplies and support from health care workers for the ongoing management of chronic diseases, including mental health conditions;
- critical facility-based therapies;
- management of emergency health conditions and common acute presentations that require time-sensitive intervention; and
- auxiliary services, such as basic diagnostic imaging, laboratory and blood bank services.

- The Essential Services Cell has met initially twice weekly and then weekly, with 4 workstreams reporting into it:
  - Planning - scoping and informing planning for delivery of essential services
  - Guidance - development and assessment of guidance for health boards and trusts
  - Assurance – development and implementation of framework to enable the system to be assured that essential services are being delivered in line with agreed guidance
  - Communications and Engagement - with professionals, stakeholders and the public
- Under the Essential Services Framework and through the work streams condition specific essential service guidance has been issued to the services to support the mitigation of harm for non-covid patients during covid-19. These included:
  - Cancer services in Wales during Covid-19
  - A Framework for the recovery of cancer services during Covid-19
  - Cardiac specialised services guidance
  - Maternity services in Wales during Covid-19
  - Neonatal services in Wales during Covid-19
  - Paediatric specialised services surge guidance
  - Paediatric diabetes services in Wales during Covid-19
  - Stroke services during Covid-19
  - A Framework to support the availability of essential medicines as NHS Wales recommences routine care
  - Hip fracture essential services plan

- Through the QA work stream two separate self-assessments across Wales have been undertaken to clarity on the status of services ability to deliver throughout the pandemic and identify any service area in need of wider support.

- Communications and engagement with the public, stakeholders and health professionals, has included
  - Weekly engagement summary of intelligence gathered from discussions with CHCs, HB Patient experience leads, feedback from Third sector organisations and health care professionals
  - Media campaigns, including ED (launched14TH May), and Cancer (launched 15th June)

- In June 2020, the WHO updated its guidance:

https://www.who.int/publications/i/item/covid-19-operational-guidance-for-maintaining-essential-health-services-during-an-outbreak

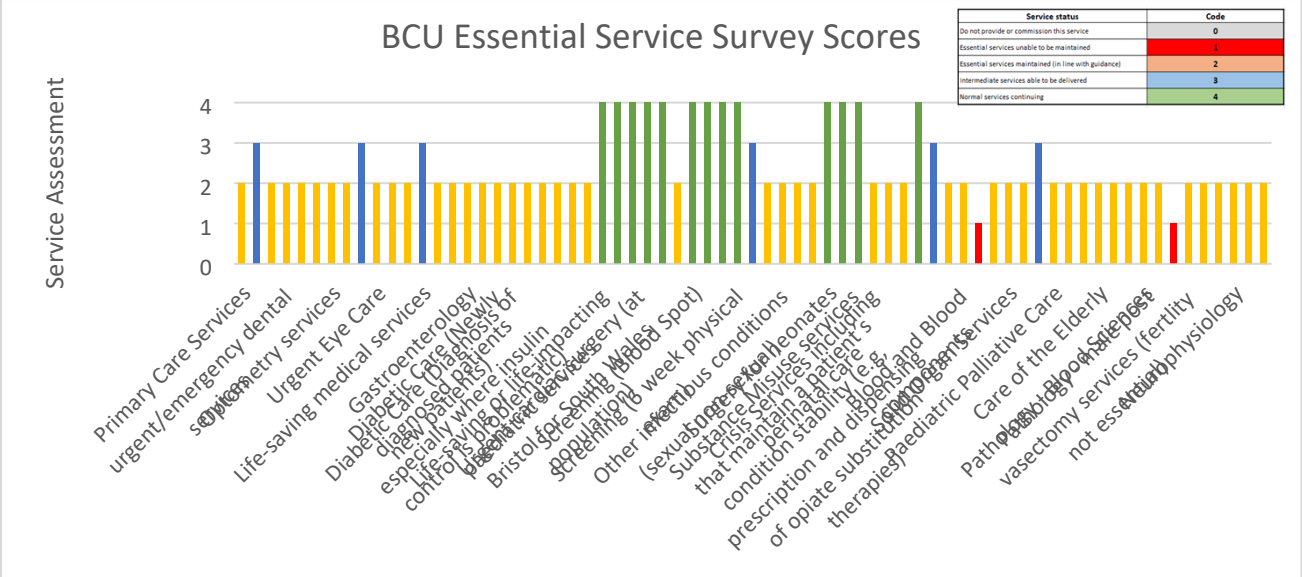
And WG have also published plans for moving out of lockdown: https://gov.wales/sites/default/files/publications/2020-05/unlocking-our-society-and-economy-continuing-the-conversation.pdf.

- It is important to remember that Essential Services must be maintained throughout peaks and troughs in level of covid-19 activity so as to mitigate harm to non-covid patients. It is nationally recognised that the delivery of essential services in the context of COVID-19 is challenging. It is not only the specific redirecting of resource to COVID specific services that can reduce the capacity to deliver essential services; essential services are also impacted by constraints on facilities and staffing that are a direct consequence of action to reduce the risk of COVID transmission in healthcare settings, in order to protect patients, staff and the wider community. It is, however, important that, in this context, essential services are prioritised. The Health board needs to be able to rapidly identify, highlight and respond to situations where the delivery of essential services is compromised or threatened and using the ethical framework for decision making. **https://gov.wales/coronavirus-ethical-values-and-principles-healthcare-delivery-framework-html**

Asesiad / Assessment & Analysis

Strategy Implications

- The disruptive nature of the pandemic has resulted in the planning cycle being shortened to at the most a quarterly cycle of business. However during the first quarter the health board has undertaken 3 internal assessments of the status of essential services and one external (commissioner focussed).
- The outcomes from the first 2 assessments have been submitted to Welsh Government. In line with most health boards essential services in general have been able to meet the standards for delivery set out in the condition specific guidance:



- In order to provide assurance further internal assessment of the compliance of essential services with the present guidelines has been undertaken. This has used an internally constructed template (appendix 1) which requires clinical leads to confirm compliance at service and location level, identify actions being taken to support compliance and mitigate risks and to raise any concerns requiring corporate support to sustain compliance going forward.
- Information from this latter assessment of compliance is being used to formulate the Q2 plans, ensuring adequate capacity to maintain essential services, while re-setting non-essential services safely within available capacity and having the ability to respond to future unscheduled care and covid-19 demands.
- BCU has historically contracted with external providers for secondary and tertiary services in England and therefore an assessment has taken place jointly with WHSSC as to the service status of these providers.
- A further national assessment is due to be undertaken shortly, which will seek out evidence to support the self- assessment scores provided to date. It is expected this will take place early in Q2.
- It is noted that delivery of the standard outlined in the guidance is a significant reduction in the normal level of activity and as time progresses guidance is being revised to support safe re-setting of services to allow additional activity to be undertaken. In doing so it is important that this additional activity does not comprise the delivery of essential service activity, nor prevent services responding to any further peaks in Covid-19 activity or forthcoming anticipated winter pressures.
- Innovation and technologically supported new ways of working are important enablers to continue to deliver essential services, providing care for vulnerable patients and supporting multi-professional and pathway working for essential services. Innovations such as consultant connect, and attendanywhere have a strong strategic fit with care closer to home and support

a risk-stratified approach to manage patients, avoiding the patient having to come onto a hospital site unless essential for their treatment.

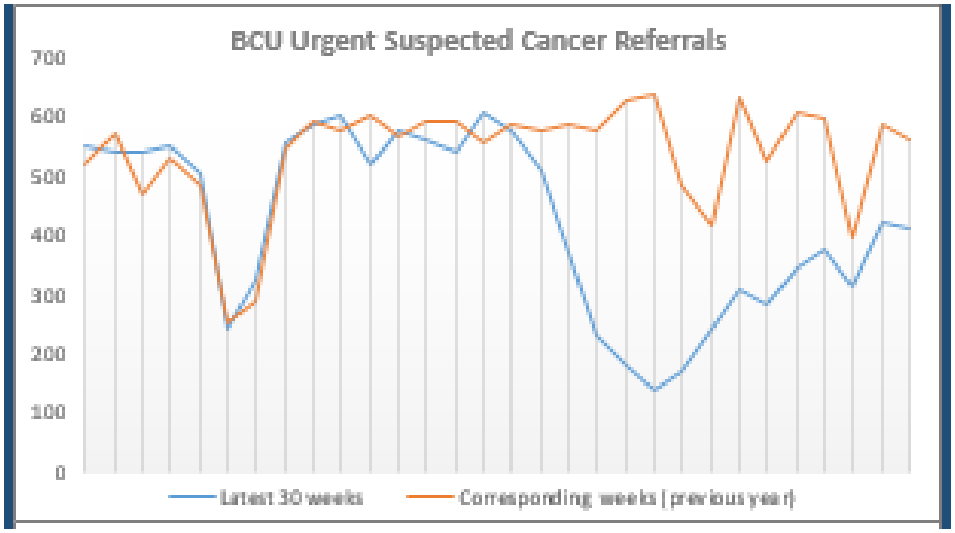
Financial Implications

The traditional cost base for calculation of efficient and effective essential services is in need of reconsideration as the capacity and hence productivity is severely reduced while the cost of treatment in accordance with social distancing, estate and PPE requirements is likely to have increased cost per case.

Risk Analysis

The delivery of Essential Services is based on risk stratification and while Essential Services are those prioritised to continue throughout the pandemic the following factors impact on the delivery of Essential Services:

- Patient confidence in accessing health care. In the initial period of the pandemic the number of referrals into some of the essential services fell radically. For Example urgent suspected cancer referrals reduced to 36% of their previous weekly mean and have recovered but remain at less than 70% of pre-covid levels of referral :



- There are a number of procedures within Essential Areas where the guidance indicates these as too high a risk to proceed at the present time.
- In high risk areas re-direction to alternative pathways or adjustment to treatment routines for some patients has to be considered to mitigate the risk of harm e.g. use of hormone therapy as opposed to surgery for some patients with prostate cancer, change in radiotherapy fractionations for some tumour sites.
- There are a number of services where historical delivery has been in partnership with other providers such as Education services and therefore the mode of delivery is impacted by other policy decisions such as the re-opening of schools.
- There are a number of patients for whom on balance of risk proceeding with Essential Services would not be clinically advised. These include patients who may be shielding or vulnerable and therefore patient by patient clinical decisions are needed in respect of the individual patients pathway. For some patients alternative pathways have been utilised and technology is being used to support contact and advice on care and treatment.

- There appears to be an increased risk of mortality in the post-operative period for patients contracting covid-19. This together with impact of nosocomial transmission during hospitalisation and the vulnerability of certain patient groups requires careful management of the overall risk. These risks need to be balanced with the risk of harm of not proceeding with treatment at this time.
- The risk to staff in delivering the care to patients is an important consideration in applying the guidelines. It has been necessary to fully assess the environment, routes for access and egress, PPE availability and communication routes to support staff and patients in delivery of essential services. This applies to the entire patient pathway and impacts on all essential services.
- Absences within our workforce and time required to donn and doff PPE and clean between cases as well as maintaining social distancing has reduced service capacity and productivity and this will remain a challenge for the foreseeable future.
- While the list of Essential Service Areas is relatively tightly defined, it is noted that the situation is very dynamic and therefore the demand is likely to change, with a greater number of patients falling under the essential service framework the longer they wait, as well as guidelines being refreshed to reflect the on-going nature of the pandemic. This may mean that patients initially deferred safely for 3 months under the original guidance will now be approaching the time where treatment becomes essential to proceed.
- Reduction in capacity to deliver services and ongoing assessment of risk and mitigating actions - interdependencies with guidance issued by Nosocomial Transmission Group– links to issues of consistency of approach and also potential need for regional solutions.
- The risk assessment needs to take a full pathway approach and consider the interdependencies between pathways for services such as diagnostics.

Compliance

- The analysis of the monitoring tool returns demonstrates that while a number of services are able to comply fully with the requirements to maintain the essential services, those services with a heavy diagnostic component to their pathway have deteriorated in their reported position over the last month. Diagnostic services are presenting particular challenges for essential cardiac and urgent surgery including cancer services for Upper GI, Lower GI and Urology.
- The position for cardiac procedures in especially concerning and is being addressed as a matter of urgency. Diagnostic procedures recommenced via the cath lab during June 2020.
- In addition phlebotomy remains challenged in delivery of its core service due to staffing and social distancing requirements. This service is reported as being under considerable pressure as a consequence.
- Urgent Eye Care, Gastroenterology, Urology and General Surgery are the specialties at greatest risk on being non-compliant, eye case being the only specialty in this category where compliance is not related to diagnostic capacity. In eye care the need for face to face consultations for chronic condition management and the time-critical nature of consultations for the population which includes a high proportion of vulnerable patients makes this service a priority to re-start its outpatient services. For the other specialties improvement in diagnostics is essential to their delivery. While endoscopy has recommenced the volume will not be sufficient to meet the demand for services and additional resource will be needed to increase the levels of activity safely.
- 23.5% of essential services surgery is being undertaken through the national agreement for use of private sector providers. This contract has been extended to 5th September 2020.

- The commissioned activity is showing some variation in its ability to recover from the covid-peak in England. Sites such as RJAH have been used for trauma care and therefore ae aiming to return to elective services by 1st August 2020, albeit at a much lower level of activity due to the social distancing, IPC and PPE constraints on productivity. They have maintained essential services from cancer, and spinal patients throughout covid-19. Countess of Chester are also reporting maintenance of essential services, with challenges to provision of diagnostic services. They are using the private sector to undertake some endoscopy and MRI lists to support these services.
- Most English providers are using a risk stratification approach of P1-P4 for future scheduling of patients.

Priority	Timescale for treatment
P1a –Life threatening	24 hours
P1b	72 hours
P2	1 month
P3	3 months
P4	Can safely wait beyond 3 months

The full summated response is included as appendix 2.

Impact Assessment

It is clear that the disruptive nature of the pandemic has had an impact not only on patients directly affected by the virus, but on non-covid patients. Despite attempts by services to mitigate harm by maintaining essential services it is clear that this position has deteriorated between the 2nd and 3rd assessment i.e. over the past month.
The key issues leading to this deterioration are:

a) Low levels of capacity in diagnostic services arising from: staffing levels, re-establishing physical capacity and return of staff from redeployment to covid-19 areas, social distancing in departments, separation of covid positive and covid-lite routes and facilities, PPE donning and doffing requirements and cleaning times required between cases. Productivity reductions are expected to be of the order of 35-50% in most diagnostic services.
b) Prolonged nature of the pandemic. Patients that were risk assessed at the start of the pandemic and considered safe to wait for up to 12 weeks are now reaching the point where they require treatment, at the same time as capacity to provide this treatment is reduced.
c) The on-going nature of the pandemic, has resulted in WHO updating their guidance in June 2020 and professional bodies issuing further guidance. These tend to increase the coverage of patients/services elements that now fall under essential service requirements.
d) Fear of covid remains a factor in a number of areas seeing patients preferring to delay their treatment. Low referral rates for essential service pathways remains a concern as to potential future harm.
e) Staffing of some services is proving challenging due to pre-existing vacancies combined with staff absences due to shielding, isolation or illness.

The full impact on staffing from TTP has yet to be realised.

The impact of care home discharge policy on future bed capacity is needing to be considered in maintaining essential services, preparing to re-start services and maintaining unscheduled care services in the light of potentially fluctuating covid-19 demands and winter pressures.

The essential services are therefore needing to be delivered in a complex environment, with a high degree of unpredictability and uncertainty. This means that planning for essential service delivery is presently in a rolling 3 week timeframe. This is in line with other health boards in Wales and reflects the requirement of 2 weeks self-isolation and swabbing for patients prior to undergoing a procedure.

On-going monitoring of compliance with Essential Services updated guidelines is required in what are dynamic circumstances.

Recommendations

The committee are asked to:

- note the content of this report
- recognise that the health board has taken steps to understand its ability to comply with essential services and in doing so has identified areas of particular challenge that need to be addressed as priority areas in the Q2 operational plan.
- the need to continue to monitor , escalating as appropriate, compliance with revised Essential Services guidelines in order to mitigate the risk of harm.

Appendix 1 : Compliance Tool:

Betsi Cadwaladr University Health Board

Essential Services Guideline Compliance

Purpose

This document is intended to:

- capture the compliance of the essential services,
- identify any challenges to securing compliance on any element of the service or in any location
- identify actions being taken to achieve compliance
- identify any corporate support needed to achieve compliance.

Background

Nationally the Essential Services Cell have issued guidelines to the service of elements of service which need to continue throughout the Covid-19 pandemic. The service leads have self-assessed service status twice since the declaration of the pandemic.

This tool is introduced as a monitoring tool across BCU to be used each month or as a means of escalating concerns on a more frequent basis as soon as a concern arises.

Process

Complete this form by **17th June** and monthly thereafter and submit by **5pm** to Jill Newman Director of Performance with copy to your Area Medical Director and Kate Clark, Medical Director for Secondary Care

Jill.newman@wales.nhs.uk

Where you are experiences issues which impact on continuity of essential services the form should be used and submitted immediately with subject line entitled: **Escalation of Essential Services.** These submissions must not wait til month end.

Essential Service being reported on:	Submitting clinical lead:	Managerial lead:
Date of Submission: 17.6.20.		

Compliance Statement for Essential Services Guideline				
	BCU	West	Centre	East
I confirm that the entirety of the service provision is fully compliant with the requirements set out in the Essential Service Guidelines issued				
I am unable to confirm full compliance for the following aspect(s) of the guidelines in the indicated health community (ticked as appropriate) – provide copy of the descriptor from the guideline which is non-complaint: Where there is more than one element of the guideline that is non-compliant please repeat above for each area				
For any area indicated as non-compliant please provide a brief description of the reasons for this, together with actions being taken				
Please indicate risk score arising from each area of non-compliance using the normal risk scoring matrix of likelihood v consequence (score 1-5 for likelihood and 1-5 for consequence where 5 is catastrophic)				
Please indicate the support requested to assist in mitigation of this risk				

Appendix 2 – Summated responses to Compliance Monitoring tool – see attached

Access to primary care services (providing essential, additional and a limited range of enhanced services that fulfil the WHO high priority categories)			
Service Status - Primary Care Services	Compliant	Detailed Comments	Rationale, Risk and Mitigating Actions
Service Status - General Medical Services	yes		
Service Status - Community pharmacy services	yes		
Service Status - Red Alert urgent/emergency dental services	yes	For Dental Services (CDS, GDS and EDS) in North Wales all essential services are being delivered in line with WAG guidance issued by the Chief Dental Officer.	Plans are being formulated to maintain this position through the de escalation process.
Service Status - Optometry services	yes	15 optometry practices formed into hubs for management of patients meeting essential services criteria	Optometry Practices provided with advise re: reopening following the Ministers announcement on 19th June 2020. They will re-open following Social Distancing and IPC advice and will risk stratify patients for those in greatest clinical need in order to prioritise available capacity. For patients not able to access local optometrists the WECs service will provide a safety net
Service Status - Community Nursing and Allied Health Professionals services	yes		
Service Status - 111/Out of Hours Services	yes		
Safeguarding services			
Service Status - Safeguarding services	yes		
Urgent Eye Care			
Service Status - Urgent Eye Care	Partially	this is considered as a high risk specialty as the number of R1 patients is continuing to increase despite the increased capacity available in Primary Care	The emergency eye care pathway has been effective with high volume of patients managed within the optometry hubs and relatively low conversion to the hospital eye service. The urgent eye care pathway for glaucoma management has not been fully implemented. Table top reviews enabled a number of patients to be safely deferred for 3 months . These patients now need to be seen and therefore proposals to restart face to face clinics are being considered , ensuring that safe practice is put in place to comply with social distancing, PPE and cleaning requirements. Clinical placements need to continue for all non medics to upskill to enable more options for patient care in the future. There is a risk that during "the social distancing period" that these placements are sacrificed, which is a short term solution but a long term workforce limiting factor. To increase physical capacity to absorb both patients and clinicians we are looking to expand estates, with the Community ODTC's/Outreach Clinics being the obvious place to explore.
Urgent surgery			
Service Status - Urgent surgery	yes	YGC- Confirmed. All of the essential services that we provide are available and compliant WMH -All Surgical and Medical specialties have been reviewed in line with the Essential Services Framework and are compliant. YG confirmed compliant with guidelines.	WMH: A review is underway to bring back on line services which have been identified as the highest risk: General Surgery , Ophthalmology, Urology
Urgent cancer treatments			
Service Status - Urgent cancer treatments	yes	Compliant with current guidelines, however this does mean some treatments have needed to be deferred and others required changes in treatment options for patients	Particular challenges relate to Upper and Lower GI and urology tumour sites , where access to diagnostics has been restircted and so delayed patients getting to treatment. Referrals for USC have reduced and recovered slightly but remain less than 70% of previous referrals. However early evidence from the breast cancer tumour site suggests disease detection remains at the previous levels. Activity to treat cancer has remained at or above previous levels in March and April but is expected to reduce in May (reported the end of June) , in part due to the bottlenecks at diagnosis. There is also a concern that late presentation may result in a demand spike into the winter , increasing pressure on the services such as radiotherapy at a time they are also trying to address the backlog. There is a risk that patients presenting late may have more advanced disease and require more extensive treatment requimes.
Life-saving medical services			
Service Status - Interventional cardiology	No	**Primary PCI** remains up and running. Significant delays to diagnosis -see CT Angiography below **'Elective' PCI and angiography** activity significantly affected by 2nd cath lab being closed and even if opened the turnover of patients will be significantly affected by COVID swabbing .This is very worrying as these patients have not been assessed for coronary intervention (PCI or CABG) or valve surgery posing a significant risk to patients and BCU. **Cardiac Devices** Cases have been booked through to August (we have not significantly reduced implants in the pandemic) Again, our capacity has been reduced to 3 rather than 4 complex cases a week due to swabbing etc In addition, it is a concern that there is no reliable 'green' pathway to have procedures done. **CABG, Valve Surgery, Ablation, TAVI,** These patients have their procedures provided mainly through Liverpool . Emergency procedures are continuing , others are deferred at present.	As of 12th June 99 patients were waiting for angiography and 28 for PCI . The risk associated with these delays is significant and needs to be considered as 20-25 . Data is available to plan for the additional capacity required to address this risk . YGC have recommenced diagnostic services from week commencing 15th June and are pulling together a recovery plan to address the current backlog.
Service Status - Acute coronary syndromes	No	See below in relation to CTA	
Service Status - Gastroenterology	partially	Gastroenterology is able to offer essential service compliance, however is adversely affected due to delays in endoscopy	see endoscopy. This specialty is viewed as a high risk specialty and for early consideration in re-setting services on the acute sites. SOS, PIFU and virtual clinics will assist in management of patients with chronic conditions.
Service Status - Stroke Care	partially	Volume of presentations has been lower than expected and late presentation may have impacted on thrombolysis rates. A particular concern has been the continuity of the rehabilitation services for stroke	The rehabilitation service has been re-established in YGC mitigating the previous concern.
Service Status - Diabetic Care	yes	Acure sites reporting compliance with emergency and medical services	
Service Status - Diabetic Care (Diagnosis of new patients)	yes		
Service Status - Diabetic Care (DKA / hyperosmolar hyperglycaemic state)	yes		
Service Status - Diabetic Care (Severe Hypoglycaemia)	yes		
Service Status - Diabetic Care (Newly diagnosed patients especially where insulin control is problematic)	yes		
Service Status - Diabetic Care (Diabetic Retinopathy and diabetic maculopathy)	partially	Diabetic Eye Screening Wales (DESW) is not operating normal service. As in the "red" phase there exists Diabetic Retinopathy Check in Pregnancy (DRCP) whereby pregnant diabetic patients are seen in Primary Care Optometry Practices.	Discussions are ongoing with DESW Head of Service to recommence full service, and all options are being explored. This could mean extending the DRCP model to patient cohorts with qualifying risk factors beyond pregnancy alone.
Service Status - Diabetic Care (Emergency podiatry services)	yes		

Service Status - Neurological conditions	yes	The Neuroscience service across the whole of BCU is compliant with the criteria set out in the essential services guideline.	All emergency Neurology and Neurosurgery work has continued throughout. We had temporarily ceased our Neurologists visiting other Trusts to review patients, including in BCUHB.During that time urgent advice remained available via the 24/7 on-call service but also consultant and nursing telephone advice lines.Visits to other Trusts were recommenced on 8/6/20 so that urgent ward consultations can take place and remote clinics are being carried out on site.Remote clinics are via telephone or video but in some sites video has not been possible due to internet connectivity issues.Neurosurgical elective care is increasing but is not at usual levels. Elective procedures are being prioritised and triaged depending on degree of clinical urgency. Urgent interventional radiological procedures are taking place as usual. Imaging is now taking place so that all urgent or semi-urgent CT and MRI can take place.
Service Status - Rehabilitation	yes	Rehabilitation is classed as essential, and therefore NWBIS continues to provide care to ABI patients	it is becoming increasingly clear that Covid-19 will have severe adverse effects on the physical and psychological health, and that downstream health, social and economic effects may even be more dramatic. For example, not continuing to deliver a rehabilitation service to ABI patients will have numerous immediate and downstream (for example an unmanageable waiting list after the immediate Covid-19 crisis) effects. For these reasons the North Wales Brain Injury Service (NWBIS) has since the start continued to provide rehabilitation and care for the service's patients. This was (and continues to be) done as follows:At the early stage of the crisis (late March) all routine outpatient appointments were cancelled and patients informed by letter, with instructions how to contact the service for tele/digital/other follow up if required due to a deterioration in their wellbeing.All routine outpatient appointments at other community hospitals or home visits were cancelled and patients were informed by letter, with instructions on how to contact the service for tele/digital/other follow up if required.Referral rates are high for the service. Early data collected this week indicate 73 new referrals to NWBIS over the relevant three months period (2nd March – 6th June). We plan to audit our referral and activity levels to obtain more detailed, better quality performance data to inform ongoing service delivery during the crisis.The service's normal weekly referral have been suspended and referrals are screened on a daily basis by two senior clinicians to ensure response times are faster than during normal (pre-crisis) periods.Inpatients referrals have continued to be seen on the wards throughout, including those who are Covid-19 positive.Newly discharged from hospital patients are tele screened (including for Covid-19 type symptoms), and if clinically indicated as essential for their rehab, seen at home, with PPE and social distancing.Similarly, existing patients who experience a crisis or deterioration are first being tele screened, and if clinically indicated as essential for their rehab, or significant risk to psychological wellbeing, are seen at home as outlined In the previous point.Other appointments are mostly digital/telephone.The service has adequate PPE. Re-orders are placed in a timely fashion to ensure the service does not run out of PPE.No member of staff of NWBIS have contracted Covid-19 over this period.
		Compliant All three sites are doing almost the same, apart from some inherent differences, which does not affect our compliance. We have monthly Clinical Advisory Group meetings between the three sites where we discuss and share issues as well as our way of working as well.	
Paediatric Neurology			
Life-saving or life-impacting paediatric services			
Service Status - Paediatric intensive care and transport	yes		
Service Status - Paediatric and neonatal emergency surgery	yes		
Service Status - Immunisations and vaccinations	partially	Cover report til end of March showing good performance on childhood vaccinations. However with school closures there is a need to re-establish school age programme and catch up on any missed vaccinations in the forthcoming months	
Service Status - Screening (Blood Spot)	yes		
Service Status - Screening (Hearing)	yes		
Service Status - Screening (New Born)	yes		
Service Status - Screening (6 week physical exam)	yes		
Service Status - Community paediatric services for children (with additional / continuous healthcare needs including care closer to home models and community hubs)	partially	All open case reviewed at commencement of lockdown and needs assessed. Community paediatric workforce working remotely and porviding face to face as required with PPE in place.	All urgent, high risk or complex care provided with PPE in place. Some families have chosen to not have staff into their home due ot shielding, all families supported by telephone and all case regularly reviewed. Continuing Care panel and Joint Commisisoning panels with LAs continuiing to meet as scheduled.
Termination of Pregnancy			
Service Status - Termination of Pregnancy	yes	Service provided by BPAS- Compliant with national guidelines regarding essential services for termination of pregnancy during Covid	
Other infectious conditions (sexual non-sexual)			
Service Status - Other infectious conditions (sexual non-sexual)	yes	situation improved as on-line testing is now available	Online testing now available . Ability to post medications established
Service Status - Urgent services for patients			
Maternity Services			
Service Status - Maternity Services	Partially	See detailed attachment : 3 amber risks identified All other requirements Green Essential Services Monitoring tool BCU	**Amber risks :** TTP for staff risk 12 : FMUs Temporarily closed as part of the wider Health Economy COVID-19 response plans. **Risk score :8** ; Re-introduction of PROMPT training to be confirmed nationally **Risk Score:12** ;
Neonatal Services			
Service Status - Surgery for neonates	yes	Provided by Alder Hey, transfer pathway in place.	
Service Status - Isolation facilities for COVID-19 positive neonates	yes		
Service Status - Usual access to neonatal transport and retrieval services	yes		
Mental Health, NHS Learning Disability Services and Substance misuse			
Service Status - Crisis Services including perinatal care	yes		
Service Status - Inpatient Services at varying levels of acuity	yes		
Service Status - Community MH services that maintain a patient's condition stability (to prevent deterioration, e.g. administration of Depot injection)	yes		
Service Status - Substance Misuse services that maintain a patient's condition stability (e.g., prescription and dispensing of opiate substitution therapies)	yes		
Renal care-dialysis			
Service Status - Renal care-dialysis	yes		
Urgent supply of medications and supplies including those required for the ongoing management of chronic diseases			
Service Status - Urgent supply of medications and supplies including those required for the ongoing management of chronic diseases, including mental health conditions	yes		
Blood and Transplantation Services			
Service Status - Blood and Transplantation Services	yes		
Service Status - Blood and Blood components	yes	Blood Sciences 24/7 urgent service - normal service	
Service Status - Transplantation services		Presently suspended across the UK in accordance with guidelines	
Service Status - Stem Cell transplantation services	yes	Stem cell harvests are being transported to Christies by World courier who are operating as normal and have business continuity plans in place	
Service Status - Solid Organ Services		Presently suspended across the UK in accordance with guidelines	
Service Status - Platelet Services	yes	Initial concern re: blood supply has not increased at present as activity is low and so demand for blood products is under control	Access to platelets may be a particular risk going forward which will impact cancer care disproportionately
Palliative Care			
Service Status - Palliative Care	yes	The following essential services for palliative care are fully compliant presently, however, there are risks* which we have outlined in the other sections : *Specialist Palliative Care Team (SPCT) assessment, intervention, advice & support across all hospitals & community (via three SPCTs – East / Central & West). *Access to Hospice services / specialist in-patient hospice beds Hospice at Home working in partnership with community nursing and Marie Curie Nursing Service. Weekly Specialist Palliative Care (SPC) MDTs.24/7 Palliative Medicine Advice Line. MND Care Coordinator Service. Some non-essential elements remain safely, temporarily stepped down in interests of patient safety (SPC out-patients and day therapy) and alternative support provided.	***Specialist Palliative Care Team (SPCT) provision risk score 15 :** Concerns regarding maintaining adequate and safe staffing capacity to meet demand (normal palliative care population / caseload, impact of people with delayed cancer diagnosis and poor outcomes, COVID EoLC & winter pressures). Case of need in progress (for submission June) for request for temporary additional staffing to sustain essential services throughout next phase COVID & winter pressures. This is of particular concern in the community across all three areas, where SPCT nursing staffing is impacted by COVID (shielding staff) and LTS. Services have an escalation plan in place to manage referrals safely in line with available capacity, however, anticipate staffing and clinical pressures to increase which will impact upon ability to undertake visits in a timely way. ***Third sector palliative care provider (Hospices / Marie Curie) sustainability risk score 20** Revenue of third sector palliative care providers with whom we work closely, is adversely and directly impacted through COVID through inability to fundraise. This includes three adult hospices, one children's hospice and Marie Curie Nursing Service in North Wales. They all received recent allocation of emergency funding from Welsh Government to compensate for loss of charitable income but this was single quarterly payment (April – June 2020) with no confirmation of future emergency funding payments.Local SLA discussions to progress and paper to be co-produced to outline impact, risks and options. Concerns escalated to All Wales Palliative Care PCIG & All Wales EoLC Board.
Emergency Ambulance Services			
Service Status - Emergency Ambulance Services	yes	demand is lower than pre-covid and Cat A response times improved	

Additional Services			Radiology Service Overall risk 20
CT	partial	capacity is now becoming an increasing problem for providing USC and Urgent CT, MR and US scans due to the increasing demand for ED and in-patients; bed occupancy is increasing in the DGHs, in some instances to well over 90%. IPC guidance has been changed and recommencement of CTC is now possible, albeit that each examination takes an hour thereby displacing two other patients. In trying to balance its available capacity, Radiology can only accommodate 4 to 5 patients per site, per week. Although all patients	Risk to expansion of capacity via use mobile scanning facilities, as there is a return to a greater level of service demand, capacity to deliveris reduced, due to mortuary services using the scanner pads in YG and Maelor. Some concerns due to patients not attending due to Covid fears or not being referred that otherwise would.There are some 25 – 30% patients who will not attend. There is a possibility of cancer amongst this group for whom diagnosis and treatment is consequently being delayed – this is a concern, particularly as there may also be disease progression with time. Presently using Spire hospital to alay some patients fears of attending acute sites
MRI	yes	Diagnostic Mrprostate restarting after pause in prostate biopsies	
US	yes	With regard to US, all confirmed or suspected patients are scanned on the wards by sonographers which reduces scanning capacity by over 60%.	
X-ray	yes		
CT - Cardiology	No	Life-saving medical services-- Acute coronary syndromes - Non-STEMI (NSTEACS) and unstable angina (urgent treatment)	The investigation of unstable angina can include the need for CT Cardiac Angiograms and MR Cardiac scans – due to capacity constraints, Radiology is unable to provide these at the moment, a contributory factor being that, other than in the East, this is an unfunded service. During the initial stages of the pandemic, CTCA has not been provided other than for a few individual cases being accommodated to help with immediate management. There is a backlog of patients requiring CTCA (mostly classified as routine). Radiology and Cardiology are tp work together on risk stratification to support this service going forward. Radiology have been able to secure a CT gantry from the national procured capital available. This may assist by increasing overall capacity , releasing some time to the more complex and time-consuming CTAs. The Q2 plan will include proposals to support delivery of essential services, moving towards delivery of previous levels of service later on 2020/21 and finally backlog reduction. It is noted that delivery of previous levels of activity will require more machine time and staffing than currently available in North Wales
Endoscopy	No	Endoscopy capacity was serverally impacted during Covid-19	Lists have been re-established on all 3 acute sites, however throughput will be lower than previously and the backlog is significant. New pathways have been established via FIT testing to risk stratify the demand. Bowel Screening Wales will be re-starting services in July and also trying to reduce backlog on services. Therefore there is an increased demand for services and a reduced capacity to deliver. Consideration of additional mobile equipment and staffing to support is required
ECG	No	Increase waiting times for patients due to staffing constraints	
Electroencephalogram	yes	Neurophysiology	
Electromyography		Urgent EEG prior to liver transplant – normal service	
Microbiology	yes		
Pathology	yes	Cellular Pathology - normal service based on current workload	Workflow through the laboratory has changed to manage increased levels of sickness and social distancing for the workplace and this approach is suitable for the current situation. If workload increases as expected in the coming weeks, we will struggle to deliver a timely diagnostic service and maintain social distancing within the workplace. FIT testing funding not currently within Pathology budget.
Haematology	yes	Diagnosis of Haematological cancers including Bone marrow, trephines, blood films and flow cytometry – normal service	
Biochemistry	yes	FOB/FIT testing - FOB testing suspended replaced by FIT testing	
Phlebotomy	No	Acute and community phlebotomy service esp.Central and East : social distancing and staff sickness etc are severely impacting capacity, mitigated somewhat by reduced activity. However, activity is increasing week on week.	**Risk:16** Rapid recruitment underway but there is a lag period to maintain staffing levels.
Occupational Therapy	yes	Waiting list re-established and services are available. Innovations in place to undertake virtual reviews. Concerns around rehabilitation services for stroke in Central resolved.	
Speech and Language Therapy	yes		
Dietetics	yes		
Podiatry	yes		
Physiotherapy	yes		

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Management of waiting lists
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad Report Author:	Kate Clark, Secondary Care Medical Director Andrew Kent, Interim Director for Planned Care
Craffu blaenorol: Prior Scrutiny:	
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the content of the paper.

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

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

Sefyllfa / Situation:

The Health Board has failed to meet the Referral to Treatment (RTT) performance metrics and as a result has seen patients waiting for treatments and follow up appointments. To support the work required to address the back log, the Health Board has appointed on an interim basis a Head of Planned care with the Medical Director for Secondary Care acting as the clinical lead. Work undertaken to date has included review and refresh of the Access policy and meeting structures, validation of waiting lists and an outpatient transformation programme aligned to the National Planned care program. This has mainly focused on specific specialties where different ways of working can produce pathway efficiencies such as using Patient Reported Outcome Measures (PROMs) to avoid unnecessary follow up appointments and 'straight to listing' for cataract surgery to reduce the number of outpatient appointments.

A cancer harm review process was implemented at the start of 2020 to proactively monitor any potential harm to patients on a cancer pathway who experienced delays. This has not identified evidence of harm to date and has also helped to identify reasons for delays which could be avoided for other patients.

A non-cancer harm review process is planned to be implemented in 2020. Until this time, harm is identified through datix reporting and investigated retrospectively. A report was presented to QSE in January outlining a review process undertaken to identify if there had been evidence of harm as a

result of patients waiting for follow up appointments. This was specific to follow up appointments only and further information was requested to provide assurance to the Board relating to all RTT activity.

This paper attempts to outline the processes currently in place to manage the overarching waiting list including the identification of potential harm and actions taken.

Cefndir / Background:

This year to date has seen significant changes within the NHS and Betsi Cadwaladr University Health Board as a result of the Covid-19 pandemic. While this has accelerated some of the work already underway promoting different ways of working to reduce unnecessary appointments; it introduced a pause to face to face appointments which has meant an increase in overall waiting times.

This paper provides responses to questions raised.

1. Describe the processes you have in place to monitor and manage the clinical risks to patients waiting for a follow up outpatient appointment

The clinical risk for follow up patients who are beyond their target date continues to be a significant risk, a further driver to this is the covid pandemic which has meant that all of face to face follow up activity was paused from late March to this present point.

Prior to March 2020, validation of the follow up waiting list was underway with specific focus on Orthopaedics, endoscopy surveillance and Ophthalmology. Recovery plans included use of PROMs within Orthopaedics; for endoscopy surveillance, patients at highest risk were offered appointments as well as further review of surveillance waiting list following changes to National guidance to re-triage; business case for additional Intra-vitreol Nurse Injectors to enhance the capacity to treat patients with macular degeneration requiring Intra-vitreol Treatment (IVT).

Two major pieces of work have begun since March, which is the introduction of Signs and Symptoms (SOS) pathway, and for chronic disease management a process called PIFU (patient initiated follow up). This process is being introduced during May which means that patients waiting a follow up, can be placed onto an signs and symptoms pathway, once notified the patients can contact the organization if they develop signs or symptoms that would trigger a follow up or if they remain symptom free can be discharged after 6 months. Patients on a PIFU pathway will not be discharged but can be clearly “flagged” as requiring follow up.

Patients on the SOS pathway are having a desktop review to understand their suitability, if clinicians identify any potential harm or cause for concern a Datix completed. This will be investigated through the recognised process and the patient may then be offered a non-face to face consultation in the first instance.

2. Describe the processes you have in place to monitor and manage the clinical risks to patients waiting for a follow up outpatient appointment who are more than 100% overdue

Validation continues both administratively and clinically with patients over 100% overdue on follow up; this ensures that duplicate entries are removed and those patients that have been seen are corrected on PAS. Where any patients and their pathways are not fully understood, they are referred to the operational teams for a clinical validation. It should be noted that the issue with duplicate entries was exacerbated by the WPAS implementation, mainly at YGC but with some impact at

YWM. This highlighted data quality issues in recording clinic outcomes and actions taken when clinics are pooled or moved from one consultant name to another. This is being addressed through the data quality assessments for WPAS implementation in West.

Each site is currently using Datix to report potential harm in non-cancer pathways. These are reviewed via the weekly incident review meetings and reported via site quality and safety groups to the Secondary Care Quality Group. The opportunity to utilise a process similar to that implemented in North Wales Cancer Services is being explored to further mitigate the potential for harm.

3. Describe the processes you have in place to monitor and manage the clinical risks to patients waiting for a follow up outpatient appointment who have not been allocated a target review date

The organisation has the following process:
Patients should be allocated a target review date within the clinical coding post review. For patients without a target review date, the booking team raises a query with the clinical and operational team to ensure that the clinician is prompted to complete the relevant coding and target date. As a result of this practice there are currently no patients without a target review date.

Unbooked patients are reviewed in the local Patient Tracking List (PTL) meetings where actions are taken to book patients in clinical priority and time order. Where a significant delay has been identified a Datix is raised; this is then reviewed at specialty/directorate level, and where necessary escalated to divisional level for further actions to be undertaken. Currently due to the pandemic situation, follow-up activity is being predominantly offered through non-face-to-face contact.

Harm is reported through the quality and safety groups as previously described. Impacts on performance are monitored at a local level through site operational meetings and then into the Secondary Care Management Group.

4. What actions are you taking to reduce:
a. The number of patients on your follow up waiting list

A validation process is being commissioned, where an audit will be undertaken for the follow up patients passing their review date. Other measures now in place include:

- Site/Area owned Demand & Capacity planning process to establish core capacity. Capacity change request process in place to ensure good governance and assurance before an investment commitment
- Improved information management and performance governance to support operational delivery
- Grip and control on scheduling process strengthened in July 19. Frontline engagement to influence booking practice to optimise capacity
- Proactive capacity management to support chronological bookings. Monitored via weekly PTL meetings
- Weekly clinic slot utilisation report to drive clinic efficiency
- Weekly review of 30 FUs with longest waiting time
- Performance Management Framework: Command & Control approach to waiting list management
- Introduction of SOS and PIFU

b. The number of patients without a target review date

Following the introduction of the process highlighted in section 3, no patients are currently without a target review date.

c. The number of patients who are more than 100% overdue

The mid-June reporting position shows 195,918 patients are on the follow up waiting list and 61,254 of those are 100% overdue for their appointment. This has deteriorated during covid from a pre-March position of 59,314 who were 100% overdue of 210,987 patients waiting for a follow up patient. Of the total number of patients waiting for a follow up appointment, 95,842 were overdue at the end of February 2020 (pre-covid); this has reduced to 86,694.

d. Can you highlight some examples where processes have been changed as a result of the clinical reviews you have implemented?

Follow up position is now managed through weekly activity and PTL meetings. Prior to covid and the instruction to stop all face to face and 'routine' activity, this had demonstrated an overall reduction in the number of patients overdue related to their target date.

Clinical review of patients on the endoscopy surveillance list has prioritised those were deemed at risk. Changes to national guidance has meant that some patients no longer require continued surveillance. Those patients have been identified and offered information to discuss the changes and the impact on them.

As part of the Eye Care Measures work 6 ODTCs have been et up and optometrists are being appointed to support the work. This has been accelerated through the urgent eye care pathway approved by CAG which has enabled more patients to be seen locally in the community reducing the need for an appointment in secondary care. This is a component of the overarching Eye Care Business Case and will be funded non recurrently through OPD transformation fund (specific scheme set out by WG within the scheme).

5. What actions have been taken to reduce the risk of harm to patients whilst on the waiting list?

The Ophthalmology business case has already been referenced to train further nurse injectors and provide additional capacity to reduce the potential harm to patients waiting for follow for macular degeneration.

Recognising the significant backlog in endoscopy waiting times, particularly around surveillance, a paper was taken to QSE to support additional capacity in the form of a vanguard unit. This option unfortunately did not prove to provide immediate support due to difficulties experiencing in relation to water testing. During this time to improve the overall endoscopy service, a North Wales Endoscopy Board was created with a remit to improvement the quality of the service to meet standards to enable JAG accreditation. Further work has progressed in light of covid to introduce a single risk stratified approach with clinical prioritization of patients waiting and to identify where FIT testing may add value to reduce the need for endoscopy.

Waiting lists are shared with clinicians and clinical leads to enable prioritization of patients, and prior to covid would trigger the request for additional activity to see cohorts of high risk patients and attempt to reduce overall waiting times for specific groups of patients.

6. What actions are being taken to manage the waiting list?

Prior to covid, referrals received were triaged and placed on the waiting list. The waiting list was managed through patient tracking lists and access meeting to ensure that patients were booked in priority and time order. Harm was identified through datix reporting within the following parameters:
Patients attended the ED with symptoms related to the condition
Patients attended their GP with symptoms and their GP raised concerns relating to the ability to access secondary care input
At the appointment offered, there was a recognised delay or potential harm
Further detail relating to harm identified is referenced below.

The instruction to pause a significant amount of face to face activity has meant that alternative ways or working and managing the planned care demand has been considered. Triage of referrals is becoming more dynamic as clinicians contact patients by telephone to identify if a face to face appointment is actually needed. Digital solutions are being implemented to develop the advice and guidance available to primary care to reduce the need for outpatient appointments.

The outpatient transformation programme has been reviewed and priorities have been agreed which focus on risk stratification and reduction. Again recognising the inequalities in access across the Health Board, a pan BCU risk management approach is supported to ensure that patients can be offered the next available consultation in priority order. With virtual consultations, patients can be seen by clinicians in all parts of the Health Board. This will need to be supported by changes to processes and digital technology.

In order to support the current position relating to the impact of covid on surgical activity a different approach is required to enable access to healthcare interventions to be equitable. This will require a risk stratified approach at a pan BCU level prioritizing patients in line with National guidance and allocating appointments at a regional level. This will be supported by the work already started within the clinical advisory and pathways group to support and develop single clinical pathways and consistent principles of care for the Health Board.

The operational impact of this model will be monitored through the planned care groups. With respect to monitoring of harm, this will initially continue to be monitored through datix reporting. The introduction and implementation of a non-cancer harm review process will enable greater assurance and monitoring of the waiting list.

Asesiad / Assessment & Analysis

Strategy Implications

The Planned Care Improvement Group has been leading work to develop clinical pathways and transform outpatient services. This was aligned to the National Planned care programs and had already seen the development of an orthopaedic, ophthalmology and Urology business case. The presence of covid-19 infection and national guidance in relation to face to face appointments and surgical activity meant that alternative options needed to be explored sooner than planned. Clinical teams developed plans to manage patients within available national guidance supported by the newly formed clinical advisory group.

Development of clinical pathways has seen an increased use of community services such as optometry, increase use of virtual pathways especially within Orthopaedics and introduction of PROMs to reduce the need for future follow up appointments.

Adoption of digital technology to support clinical decision-making will also improve the demand management of pathways. Consultant connect offers primary care and community clinicians' access to specialist support. In other organisations, it has reduced referral to secondary care by up to 20%. It also enables advice to support appropriate investigations ahead of a clinic appointment to reduce unnecessary travel and repeat visits.

Clinical triage of referrals to identify if patients can be assessed by a telephone call or virtual modality has been implemented in a number of specialties to reduce risk while waiting for a face to face appointment. The outpatient transformation program is advocating use of virtual technology wherever possible to enable cross-site working and reduce unnecessary patient travel. This can also assist in reducing waiting times by accessing capacity across all of North wales rather than only offering access in the local area.

Financial Implications

Development of new ways of working will require review of the current financial agreements to ensure that funding is appropriately aligned. Further work is required across the planned care footprint to complete this work for pathway changes made to support patient care through the covid pandemic.

Risk Analysis

Review of datix was undertaken to identify incidents linked to the outpatient department from 1st Jan 2018 to 31st May 2020. All locations undertaking outpatient activity was included, this identified 868 incidents. 742 were recorded as negligible, 37 minor, 63 moderate and 26 major. No catastrophic incidents were recorded. All moderate and major incidents were reviewed for evidence of harm. Of the 89 cases reviewed only 7 were identified to have caused potential harm relating to delays in accessing an outpatient appointment. 1 incident recorded multiple examples of patients having their R codes incorrectly recorded resulting in inaccurate prioritisation. The underlying issue was identified rlating to the coding practice of R2 and R3 codes. As a result all R2 and R3 codes were reviewed and re-prioritised where necessary. No actual harm was identified.

5 incidents were related to the failure to review results in a timely manner and arrange necessary follow up. Learning was identified in these cases related to processes and communication. Of these

5 cases, 2 cases remain under review, 1 case suggests that while the diagnosis was terminal irrespective of the point of diagnosis, palliative treatment may have been offered if the diagnosis was made earlier. 2 are being managed under PTR.

The final case was a delay in offering a follow up appointment due to coding error, this was identified during a validation exercise. The patient was contacted and offered a follow up, deterioration in visual acuity was noted.

The incidents recorded did not relate to prolonged waiting times for first appointment. Trends suggested that referrals were triaged and investigations requested to facilitate appointments. The process to review results was highlighted as concerns in the majority of the cases. Reviews of the cases also identified poor communication resulting in delays to take action.

Review of the incidents submitted suggests that validation and triage of referrals identified several of the incidents. A process to proactively review delays to identify harm would be beneficial to provide a further level of assurance when appointments are delayed.

There is a secondary care risk outlining potential harm in relation to the delays in reviewing results. This is being managed through the creation of a results management project board to provide a robust level of assurance and paperless reporting. This project is due to be completed by the end of October 2020.

Legal and Compliance

Outline any legal implications of the proposal. Outline what KPIs and/or reporting back to the Board will occur during and after implementation.

Impact Assessment

Outline whether due regard has been taken of any potential equality/Welsh Language/quality/data governance implications arising from matters addressed in the report. Some proposals, particularly those relating to policies, procedures, or delivery of services may require an impact assessment to be carried out. This section should include brief details of the outcome of such assessments, and confirm whether any mitigating actions will need to be taken as a result and associated milestones / timeframe.

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Pharmacy & Medicines Management Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad Report Author:	Mrs Louise Howard-Baker Assistant Area Director Pharmacy & Medicines Management
Craffu blaenorol: Prior Scrutiny:	Dr David Fearnley, Executive Medical Director
Atodiadau Appendices:	-

Argymhelliad / Recommendation:

The Committee is asked to receive the report for assurance

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

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

Sefyllfa / Situation:

The COVID-19 pandemic placed a significant pressure on supply chains, community and hospital-based pharmacy services to maintain routine medicines supplies for patients in north Wales during the crisis and planning for return to routine care provision.

Cefndir / Background:

Due to the Global nature of the COVID-19 pandemic, countries were competing to maintain adequate supplies of medicines for patients infected with coronavirus, which created acute shortages. These included antimicrobials, critical care medicines, antiviral agents and the means to supply oxygen. This was compounded by ongoing national shortages of medicines, for a number of reasons e.g. ranitidine due to concerns about the carcinogenic properties of one of the excipients; a noradrenaline shortage following the lockdown in Wuhan, where the base product is produced.

Asesiad / Assessment & Analysis

1. Update on the current position with regards to access to critical medicines:

The four UK nations worked together to ensure that stockpiling by NHS organisations could not take place to the detriment of patients in other organisations.

80 critical care medicines were identified, of which 35 are essential for invasive ventilation and of these 35, a subset of 20 required an active supply chain management to ensure stocks availablity.

The 20 priority medicines fall into the following four broad categories:

- Analgesics (e.g. alfentanil and morphine)
- Neuromuscular blocking agents (e.g. cisatracurium and rocuronium)
- Sedatives and anaesthetics (e.g. propofol and midazolam)
- Vasopressors (e.g. noradrenaline and metaraminol)

Added to this list in Wales, were the haemofiltration dialysis fluids for COVID-19 patients with renal failure, following a national shortage, when Baxter were unable to meet global demand.

The Department of Health and Social Care set a national allocation for Wales for critical medicines, which is equivalent to 5% of the total UK stock. Each health board receives their pro rata allocation based on demand and population. However a mobilisation plan was also put in place so that should the need occur, stocks could be moved between health boards.

In BCUHB, a critical care pharmacy network was established. This group meets daily with the procurement lead pharmacists, the hospital pharmacy operations leads and the sterile production leads. The output of this collaboration was:

a) A daily Situation Report (available on request) of the top 20-priority medicine and haemofiltration fluid stocks, patient occupancy and critical care levels checked daily to provide reliable data. This facilitates planning for transfer of stock between the three acute sites if needed, and communicating when the use of second line agents is indicated to critical care clinicians.
b) The production of thousands of doses of ready-to-use critical care medicines to reduce waste; improve safety through the reduction of risk of contamination and error when medicines are prepared at the bedside. It also released time for nurses to deliver care rather than preparing medicines.
c) Over-labelling of COVID-19 supportive medication (antimicrobials, inhalers etc.) which can be mobilised within acute or primary care as needed. These are supported by patient group directions, which are ready to use by the approved healthcare professionals.

2. End of life care medicines

Suppliers of some medicines routinely used in end of life care e.g. diamorphine and levomepromazine have been unable to meet demand in the last 12 months. Other medicines e.g. midazolam are routinely used in critical care and so during the COVID-19 pandemic, measures have been put into place to provide assurance that patients at the end of life have access to essential medicines and consistent care. These include:

- The introduction of a standardised “Just in time” Emergency Medical Pack (JEMP). Pre-prepared by NHS Wales hospitals, they contain six injectable medicines essential for end of life care. Arrangements were put in place to enable the JEMP boxes to be available with a patient once a decision to prescribe was made anywhere in Wales within 2 hours 24/7.
- National guidance to support the limited reuse of medicines prescribed for one patient by others in care homes and hospices during the COVD-19 pandemic.

- Nominated Community pharmacies will provide an Enhanced service for palliative care medicines supply where additional stock will be held as planned for access to patients during working hours.

3. Access to novel therapies for the treatment of COVID-19 including investigational medical products and medicines available through schemes to promote earlier access; contributing to measuring outcomes and supporting pharmacovigilance

Working with BCUHB Research and Development (R&D) The pharmacy governance team, the R&D pharmacist and the procurement team have been proactive following receipt of the Chief Medical Officer asking NHS organisations to support the Recovery Study and subsequently the REMAP-CAP study.

They:

- Identified Primary Investigators for each site.
- Supported the set up of the trials.
- Ensured that medicines were available for each arm as it opened.
- Set up protocols.

As a result, patients with COVID-19 or suspected COVID-19 on all three sites have had the opportunity to access medicines that would otherwise not have been available to them. The recruitment status of the trials on 23rd June 2020 was:

RECOVERY TRIAL Randomised Evaluation of COVID-19 Therapy				
This national clinical trial aims to identify treatments that may be beneficial for people hospitalised with suspected or confirmed COVID-19. It is open to all hospitalised, COVID-19 patients in the UK. It is open for recruitment for ADULTS in all 3 acute sites and CHILDREN in YWM.				
UK participants		11788		
Active sites		176		
	YG	**YGC**	**YWM**	**Total**
Study participants (BCUHB) (ADULTS)	**27**	**28**	**23**	**77**
Study participants (BCUHB) (CHILDREN)	**-**	**0**	**0**	**0**
Randomisation 1 Part A				
Best supportive care	11	13	12	36
Hydroxychloroquine	0	3	3	6
Arm closed due to safety concerns				
Lopinavir/ritonavir	10	5	2	17
Corticosteroid	0	4	5	9
Arm closed to ADULT recruitment (recruitment target reached)				
Azithromycin	6	3	1	10
Randomisation 1 Part B				
No additional treatment	Stock is scheduled to be received on 24/6/20			
Convalescent plasma				
Randomisation 2 For patients with progressive COVID 19 and evidence of hyper-inflammatory state				
No additional treatment	Available to BCUHB from w/c 22/6/20			
Tocilizumab				

REMAP CAP (Randomized, Embedded, Multifactorial Adaptive Platform trial for Community-Acquired Pneumonia)		
REMAP-CAP is a trial that evaluates multiple aspects of care of ADULT patients who are admitted to an Intensive Care Unit with severe Community Acquired Pneumonia. It has been adapted in 2020 to evaluate the effective treatment in the management of COVID-19 infection. It is open to recruitment at YGC and YWM		
	YGC	**YMW**
Participants	0	3
Steroid domain		
No corticosteroid	Recruitment suspended following CMO guidance on dexamethasone treatment in COVID-19	
Hydrocortisone 50mg IV every 6 hours for 7 days		
Hydrocortisone 50mg IV every 6 hours, only while in septic shock		
Antiviral domain		
No antiviral agent against COVID-19	Not open	Open
Lopinavir/Ritonavir	Not open	Open, available
Hydroxychloroquine	Treatment withdrawn due to safety concerns	
Immune Modulation Domain		
No immune modulation against COVID-19	Open	Open
Interferon beta 1a	Open, not yet available	Open, not yet available
Anakinra	Open, not yet available	Open, not yet available
Tocilizumab	Open, available	Open, available
Sarilumab	Open, not yet available	Open, not yet available
Immunoglobulin Domain		
No immunoglobulin against COVID-19	Open	Open
Convalescent plasma	Open, not yet available	Open, not yet available
Therapeutic Anticoagulation Domain heparin or subcutaneous low molecular weight heparin		
Local standard venous thromboprophylaxis	Open, available	Open, available
Therapeutic anticoagulation with intravenous unfractionated	Open, available	Open, available

On 16th June 2020, the UK Chief Medical Officers issued a COVID-19 Therapeutic Alert, following early analysis of the RECOVERY trial results, indicating Dexamethasone in the treatment of COVID-19 (dose as per RECOVERY study protocol) for

- Hospitalised Adults
- COVID-19 (suspected or confirmed) in patients having oxygen therapy, non-invasive or invasive ventilation, or ECMO

- In pregnancy or breastfeeding women, prednisolone 40 mg administered by mouth (or intravenous hydrocortisone 80 mg twice daily) should be used instead of dexamethasone.

4. Community access

At the start of the pandemic, there was a real and valid concern that community pharmacies would cease delivery of medication, which would affect vulnerable, frail and shielding patients. Welsh Government have made provision of an additional 7.4p per item dispensed where community pharmacies declare that they are supporting access to medicines for shielding and self-isolating individuals. This support can include working with patients and their carers to arrange collection by friends or family, helping patients to access volunteer support, pharmacy-run delivery services, or postal delivery. To date, 149 of the 152 pharmacies in BCUHB have made this declaration.

In addition, the primary care pharmacy team and community pharmacies are working hard to increase the use of repeat dispensing, which improves the management of repeat prescriptions and reduces administration tasks associated with issuing prescriptions. Although there have been some initial teething problems, where this has been implemented, pharmacy and GP practice teams have been reporting improved work flows and patients are able to access their medicines more easily.

Wherever possible the prescribing intervals are being restricted to 28 days, to avoid unnecessary pressure on the supply chain, particularly as manufacturers impose a cap on some medicines. This mitigates against patients running out of medicines for chronic conditions.

A BCUHB community pharmacy escalation tool was developed following reports of closures, and staffing issues early on in the pandemic. This information is reported daily to BCUHB, and although a national tool has been developed and reported online, on the NHS Wales Shared Services Partnership Primary Care Services NECAF platform, BCUHB is currently unable to access this data, but has used the updates to set up a Situation Report (available on request).

At the start of the pandemic, steps were put in place to protect Homecare suppliers, so newly initiated patients were supplied their high cost medicines from the three acute hospitals. An exit strategy is now in place to allow the Homecare companies to plan provision for these patients, so that they can take over the supply.

3. Current medicines shortages

The Department of Health and Social Care (DHSC**)** has resumed issues of the medicine shortages bulletins. The procurement team, with their local intelligence, work with the clinical pharmacists and clinicians to ensure wherever possible stocks are preserved, by centralising them and allocating according to greatest need; purchasing 2nd or 3rd line agents or unlicensed products if necessary.

4. Risks to medicine supply line

A number of the 20 priority medicines are used in critical and routine care for induction of general anaesthesia, sedation and pain relief in investigational procedures (e.g. endoscopy). Because these medicines are used in significantly higher does in critical care, in the medium term, it is likely that access to some medicines will be limited.

As routine care returns there may be a need to utilise 2nd or 3rd line agents, which introduces new risks with clinicians using therapeutic agents with which they have limited experience when undertaking procedures or providing aftercare. The pharmacy team will work with clinicians to mitigate these risks, but they do need to be involved with planning the return to routine work, in order to ensure that sufficient medicines are available to meet all the demands.

Strategy Implications
Quality Improvement Strategy: Achieve the Highest Level of Reliability for Clinical Care

Financial Implications
There are financial implications with increased medicines costs. This is a result of the following:

- Use of critical care medicines increased, due to demand and the significantly higher doses used in these units.
- Purchase from suppliers outside the Welsh Contract, 2nd and 3rd line, or unlicensed products incurs higher costs during acute shortages.

Risk Analysis
Medicines shortages are on the BCUHB risk register and the risk was initially scored as 15. However, with all the mitigation described above, it is currently scored as 10. Oxygen was originally rated as 25 and has since reduced to 15 following recent infrastructure improvement at Ysbyty Gwynedd, Wrexham Maelor along with the Temporary Rainbow Hospitals.
The renal replacement fluid risk analysis, due to international demand is currently scored as 15.

The absence of electronic prescribing in hospitals along with lack of electronic transmission of prescriptions in the community remain key risks in BCUHB and NHS Wales. NHS England have implemented these systems and has enabled safe working remote clinical practice and business continuity during Covid 19.

BCUHB identified that at the peak there would be a shortage of Braun volumetric and Syringe pumps which are used on general wards as well as critical care. In addition this would include a shortage of ambulatory syringe drivers for palliative care.

To mitigate this risk the general IV guidelines were updated to prefer bolus dosing and identify where “gravity flow” infusions are safe. These changes were approved by nursing leads. The necessary sundries were co-ordinated by Medical Physics and put on stock in Denbigh stores and a training programme prepared which is being included in the back to basics and return to floor training.
Acute and community sites have been asked to identify and return ambulatory syringe drivers where possible. Further contingency plans involve the inclusion of subcutaneous dosing in pathways if ambulatory syringe drivers are not available.
A number of orders were placed with procurement for both Pumps and drivers. These are on the procurement list but Wales are not being prioritised as Cwm Taf recently received an order for 800 pumps and it is believed that these could be shared across Wales. This is being actively pursued.

Legal and Compliance
The “Just in Case” Emergency Medicine Packs (JEMP) provision currently does not meet the legal requirements for controlled drugs. A risk assessment was undertaken on a Wales-wide basis when the scheme was devised at the start of the pandemic and all agreed that the benefits outweighed the risks. However, as the initial crisis has passed, BCUHB has requested that the governance arrangements are revisited to ensure that the scheme meets the regulations. This will be included on the risk register including mitigation.

Impact Assessment
No impact

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Mortality review update
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad Report Author:	Dr Melanie Maxwell, Senior Associate Medical Director
Craffu blaenorol: Prior Scrutiny:	Nil
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The Committee is asked to note the content of this paper and support the proposed way forward - recognising that progress has been halted due to the Covid 19 pandemic.

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

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

Sefyllfa / Situation:

Due to the Covid 19 pandemic the improvement work planned for mortality reviews has not progressed.
Modelling suggested an extra 175 deaths a day at peak across the HB and therefore it was considered unmanageable to support the review process fully. However, it was agreed that the stage 1 mortality screen would continue to provide some oversight of deaths and ensure those deemed as serious incidents would be referred through the incident at Putting Things Right (PTR) system. It would also provide some information about the reason for review so that if there were significant amounts of stage 2 requests specific categories could be targeted; such as where there were concerns expressed by families, health care staff or the reviewer.

During the pandemic the focus has been on operational processes to support death management and administration. Robust Covid 19 monitoring information has been available for inpatients. National mortality reporting systems have been implemented to support epidemiological knowledge; this has included primary and community care – BCUHB has completed this for over 80% of Covid 19 deaths since May 2020 and has contributed 36% of the national dataset (to 12th June 2020).

Access to ONS data has been made available to the Informatics department as part of these developments. This affords a real opportunity going forward as for the first time we have data on cause of death and where the patients died that should support deaths surveillance within the community.

This report will provide some reassurance that mortality during the Covid 19 pandemic has not increased for non-Covid causes and will also describe the action to re-invigorate the review process.

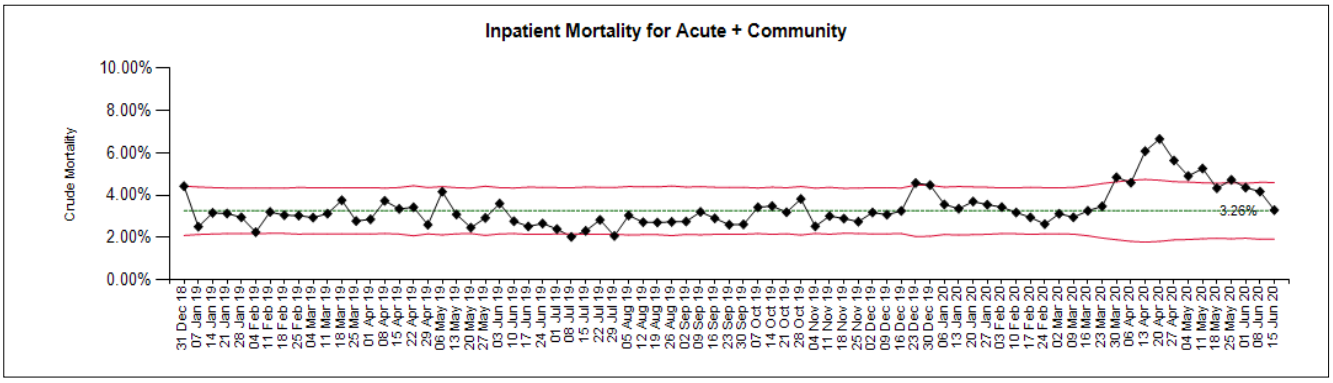
Cefndir / Background:

Mortality reviews using retrospective reviews of the medical case record is long established as a governance tool and is mandated within Wales for inpatient deaths. This should enable healthcare organisations to learn from deaths and provide assurance. Studies have estimated that approximately 5% of deaths within hospital settings maybe related to substandard care (Brennan et al., 1991) (Hogan et al., 2012). (Hogan et al., 2014)

Whilst as a Health Board we have struggled to show changes in practice following death reviews. It is clear that in the most serious cases; those in the PTR system or who were referred to the Coroner, there are action plans and learning is shared. We need a process that provides similar levels of assurance for death reviews more generally.

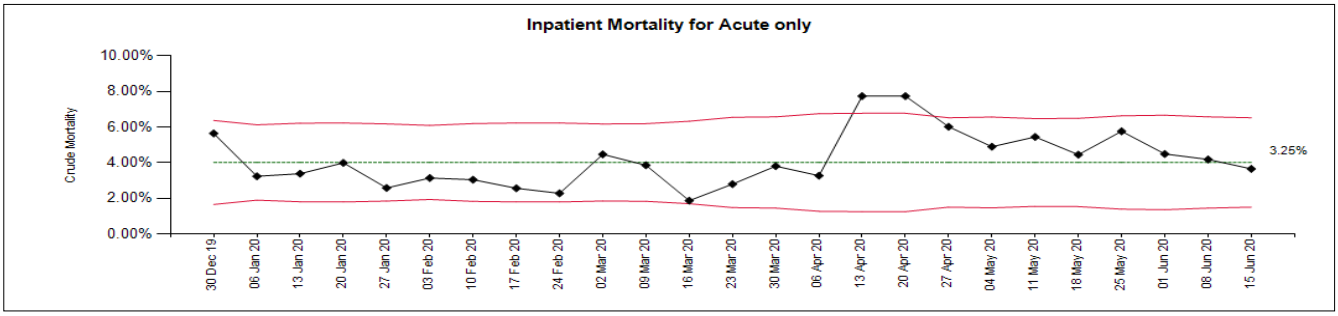
Mortality overview 2020:

From the end of March 2020 to the end of May the crude death rate within BCUHB inpatients has been higher than expected:

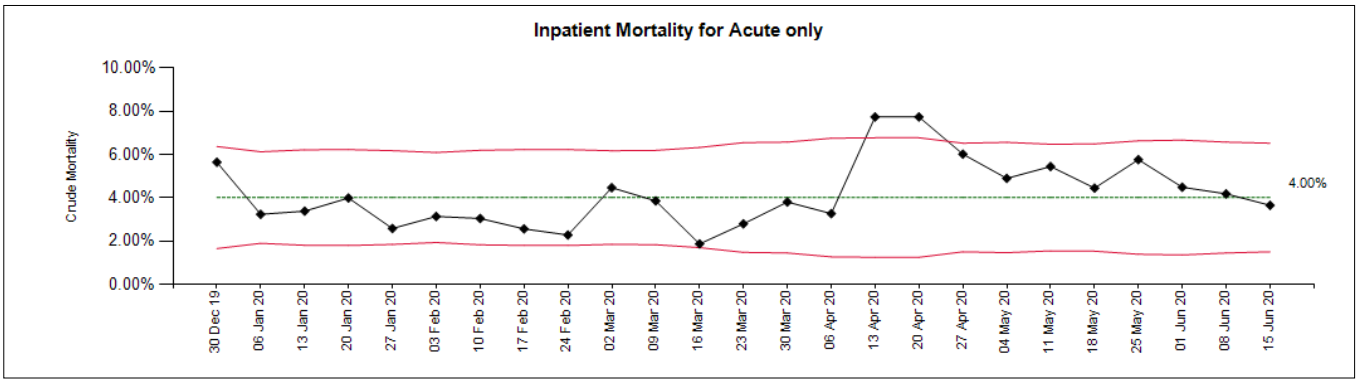


This is predominantly within the Acute sector; similar patterns are seen in the WMH and YGC:

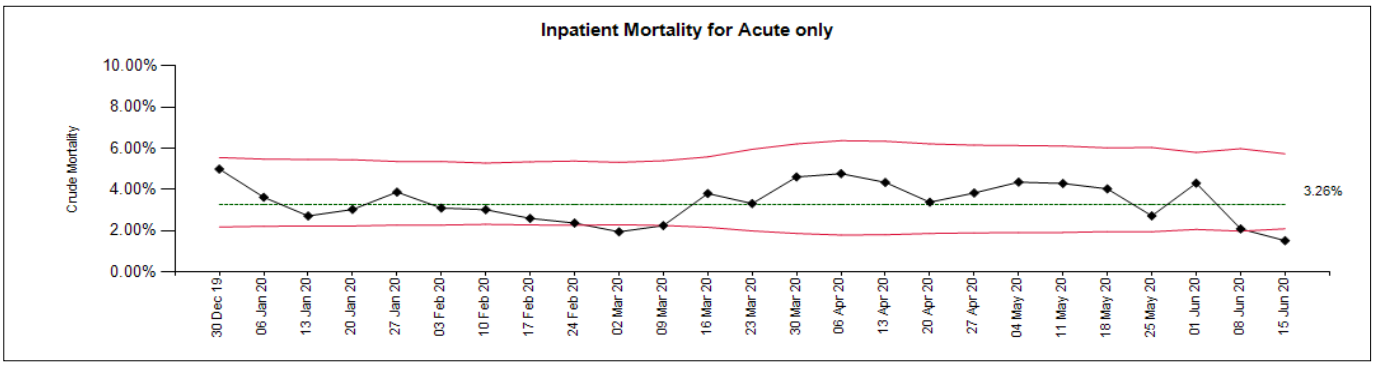
East:



Centre:



West:



CHKS data to the end of April show BCUHB has a lower mortality than the Welsh Average.

Covid 19 impact – Mar-May 2020:

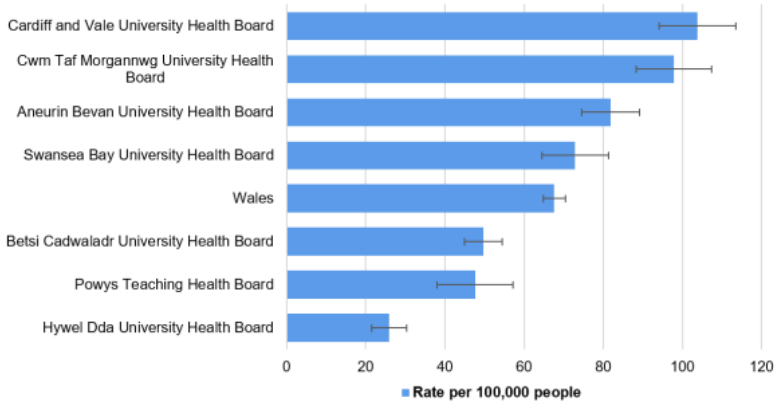
Information available from NWIS shows that BCUHB residents have seen a daily death rate similar to the three year average for non – Covid deaths (2017-19) with less inpatient deaths (NHS) than expected. The excess deaths seen are related to Covid 19; where BCUHB has seen a slightly different pattern to elsewhere with a flatter, more sustained death rate, although this is decreasing now.
This data is from the Office for National Statistics (ONS) and is the most robust data available as it is the output of the legal requirement to register deaths.
https://isdapps.wales.nhs.uk/COVID-19/rdPage.aspx?rdReport=COVID-19.Reports.Mortality&ClickedFrom=&rdRnd=28553

At health board level, the lowest rates were seen in Hywel Dda; rates in Powys and Betsi Cadwaladr were also below the Wales average. There is also variation within a health board area. Within Betsi Cadwaladr, rates are highest in the North East (Denbighshire, Flintshire and Wrexham) and lowest in the Isle of Anglesey.

The highest rates on a monthly basis were seen in South Wales in April, but in May some of the local authorities in North Wales had the highest age-standardised rates. Whilst the rates for South Wales declined in May, the mortality rates in North Wales authorities were more stable. But even in those areas of North Wales, in May the mortality rates are fewer than 40 deaths per 100,000 people – in

contrast in April, 11 local authorities had mortality rates of over 40 per 100,000. This highlights the decline in mortality during May, and also the different picture in North Wales, which has seen a less pronounced “peak” than other areas in Wales.

Chart 2: Age-standardised mortality rates for deaths involving COVID-19, per 100k population and local health board, for deaths occurring between 1 March and 31 May 2020



Source: The Office for National Statistics

Table 2: Age standardised COVID-19 mortality rates per 100k, March to May 2020

	March	April	May	March to May
Isle of Anglesey	:	6.3	22.2	28.5
Gwynedd	3.6	23.4	14.0	41.0
Conwy	:	19.8	17.7	38.2
Denbighshire	2.4	34.9	38.4	75.7
Flintshire	2.4	38.4	29.0	69.8
Wrexham	:	20.0	23.5	45.0
Powys	2.2	33.2	12.2	47.6
Ceredigion	:	4.1	:	7.2
Pembrokeshire	:	15.0	8.8	23.8
Carmarthenshire	1.4	18.5	15.3	35.3
Swansea	5.2	55.0	16.4	76.6
Neath Port Talbot	2.2	43.0	21.4	66.6
Bridgend	3.2	43.4	14.0	60.6
Vale of Glamorgan	8.0	40.3	14.8	63.0
Rhondda Cynon Taf	5.8	83.9	28.8	118.5
Merthyr Tydfil	:	84.8	26.3	111.0
Caerphilly	14.9	53.7	7.1	75.7
Blaenau Gwent	12.4	67.9	9.2	89.5
Torfaen	14.0	46.1	5.8	66.0
Monmouthshire	9.2	29.3	18.5	57.0
Newport	17.6	71.0	28.4	116.9
Cardiff	6.9	87.0	30.7	124.5

Source: Office for National Statistics

: = the age-standardised rate is unavailable.

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31may2020

Asesiad / Assessment & Analysis

Stage 1 reviews have continued to meet the target of 95% on two sites. Wrexham Maelor has improved compared to last year. Work is ongoing to ensure completeness in WMH:

Jan - May 2020	Deaths	Stage 1 completed	% Stage 1 completed	Stage 2 required	Stage 2 outstanding	% Stage 2 completed
YGC	539	538	99.8%	84	74	11.9%
YG	352	340	96.6%	54	53	1.9%
Wrexham	463	399	86.2%	65	45	30.8%

277 triggers for stage 2 were recorded review this year of which 47% of these were also referred to the Coroner; a third died within 30 days of surgery; almost12% of families raised a concern and 4% of the reviewers were concerned about care. These trigger groups are not mutually exclusive.

As we move forward with normal business, and in discussion with the area and site Medical Directors we have agreed to hold workshops in July to update knowledge on Medical Examiners, the use and access to Datix mortality module and review the process for stage 2; the output of this will be a renewed learning from deaths policy and process that focusses on learning.

For Areas, we will be exploring the ONS data with the Informatics team to determine how we might be able to implement surveillance across the service. Mental Health /Learning Disability services will be included in this work. This work will support the implementation of the recommendations as agreed in March 2020 (see below)

Strategy Implications
Embedding a robust deaths process will support the quality and safety agenda within the organisation. Reducing healthcare associated harm and death is a key aim of the Quality Improvement Strategy. Thematic analysis will enable the development of a robust improvement plan that is relevant to BCU.
The application of this process will ensure the organisation is ready to respond to the potential challenges of the Medical Examiner system (due to commence Autumn 2020). Patients will benefit from improved care and increasing openness.

Financial Implications
The expectation is that this work will be undertaken in SPA time for doctors, recognised within job plans.

Failure to have a robust review system will reduce the ability to learning lessons from deaths and may repeat inadequate care across the organisation and limit reduction in avoidable harms and death.
BCU will also risk being inadequately prepared to respond to the introduction of the Medical Examiner.

Mortality reviews have now been entered as a tier 2 risk via the Office of the Medical Director risk register which is linked to secondary care. Currently risk rating remains at 15 with inadequate controls in place.

ID	Ref	Handler	Title	Opened	Closed date	Risk Type	Risk level (current)	Risk level (Target)	Risk Rating (current)	Date of Last Review/Update	Date of Next Review	Area/Secondary/Corporate
3025	OMD QI	Mrs Mel Baker	There is a risk to the organisation around the failure to complete universal mortality reviews	08/01/2020		Tier 2 - Directorate	Extreme	Moderate	15	03/03/2020	31/03/2020	Office of the Medical Director (Corporate)

Legal and Compliance
Compliance with the Medical Examiners system, once introduced will be enhanced.

QSG should receive updates on mortality reviews to be reported on the site and divisional issues of significance (IoS) reports. Any concerns from deaths statistical surveillance will be highlighted by RAMSG IoS report.

Milestone – redevelopment of the Learning from Deaths policy; reduction in the backlog of Stage 2s

Quarterly mortality report should be available to QSE - including death statistics, lessons learnt and actions taken based on the information above.

Impact Assessment

None required

Appendix 1: Recommendations agreed in March 2020:

1 .There is clarification of responsibilities and accountability
The Office of the Medical Director, holds responsibility for
- Setting and agreeing a strategic direction.
- Working with operational divisions to design and establish systems for mortality review across the health board including leading the development of reporting systems.
- Scrutiny and assurance of both the process and findings

Operational divisions are responsible for:
- Day to day management of the process

- Ensuring sufficient numbers of appropriate personnel are employed to meet need, received appropriate training and time to complete the reviews
- Monitor performance against policy standards - extracting learning, developing and deploying action plans
- Reporting on findings within normal governance processes with escalation as appropriate

2. Divisions confirm approval of the two stage review process

The paper process is as documented in the current policy with the understanding that

- Serious Incident Report- if a death already allocated to PTR processes, then it need not proceed through the Stage 2 process
- All deaths in patients determined at Stage 1 (or Medical Examiner in future) as "Serious Mental Illness" or "Learning Disability", automatically qualify for "Stage 2" review, after which they undergo further review within the Mental Health & Learning Disability Division.

3. Divisions agree and apply a management structure

For example,

a. Each site will appoint a hospital clinical lead for mortality review
b. Each Hospital Management Team establish a Mortality Review Group to performance manage the process. This would report through the relevant site and/or divisional Quality & Safety group.
c. Ensure there is a focus of activity on Stage 2 reviews

4. Systematised linkages are established between M&M and Mortality review

All "Stage 2" reports relevant to individual departments, should be reviewed at the relevant M&M meeting with documentation of discussion, outcomes and learning, including conclusions about outstanding care and sub-optimal care, formally recorded. This information would be shared with the relevant site and/or divisional Quality & Safety group, with cross divisional learning shared at RAMSG.

5. Address the backlog of stage 2 reviews

Ideally we would wish to remove the backlog and work within a 6 week timeframe enabling learning whilst patients are still remembered. It will take approximately 600 hours work to complete the current backlog and so a way to reduce this needs to be found. The suggestions are to:

- Identify those patients in the backlog who have been reviewed through the PTR process, complaints and Coroner's inquests and remove them
- Identify and then remove patients who were referred for HCAI or falls with no other referring criteria, on the grounds that significant numbers of reviews have been completed, the lessons known and action plans are in place to address these.
- Explore opportunities for further reductions

Work has started to reduce duplication in the backlog.

Cyfarfod a dyddiad: **Meeting and date:**	**Quality, Safety and Experience Committee** **3.7.20**
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Services Update
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr David Fearnley, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Joanne Garzoni, Vascular Network Manager Kate Clark, Secondary Care Medical Director
Craffu blaenorol: **Prior Scrutiny:**	Vascular Task and Finish Group
Atodiadau **Appendices:**	Appendix 1 – Vascular Task and Finish Group Terms of Reference Appendix 2 – Draft Vascular Network Action Plan v0.3 Appendix 3 – Vascular Stakeholder Engagement Plan

Argymhelliad / Recommendation:

The Committee is asked to

- note the progress made by the Vascular Task and Finish Group
- approve the draft terms of reference for the Group

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

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

Sefyllfa / Situation:

This report provides an update to the Quality, Safety and Experience Committee on the work undertaken to date by the Vascular Task and Finish Group.

Cefndir / Background:

In July 2019, following the centralisation of the major arterial vascular service in April 2019, it was agreed that a review would be prepared with the principle objective of assessing the impact of the vascular services provided across the North Wales Vascular Network in the post implementation period. The presentation of the report was delayed due to the COVID19 pandemic. This review was presented to the Health Board on 22nd May 2020 with recommendations to address areas for improvement.

The Health Board approved the establishment of a Task and Finish Group, chaired by the Executive Medical Director, to oversee the implementation of the vascular services review recommendations. This group would consider the draft action plan to identify any further required actions and recommend key performance indicators. It was agreed that progress reporting arrangements would be via the Quality, Safety and Experience Committee.

Asesiad / Assessment & Analysis

Strategy Implications

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

Updates to the Group

Good News: Vascular Access

At the National Vascular Access meeting held on 22nd May 2020 the Health Board reported that in June 2019 there were 116 patients awaiting renal access surgery across North Wales. The Vascular Network have reduced the number of patients waiting for renal access surgery to 41 in 11 months; with 9 patients waiting for procedure in Ysbyty Gwynedd, 10 in Glan Clwyd Hospital and 22 in Wrexham Maelor Hospital. The actions required to improve and maintain the service have been jointly led by the renal and vascular services to ensure a unified approach. As a key part of the vascular surgery COVID recovery plan and to ensure the sustainability of the service and safe and timely availability of surgery, the Health Board will continue to provide dedicated vascular access operating lists per week which will be ring-fenced away from the wider vascular surgery lists with no disruption caused by surgical on-call requirements.

Vascular Task and Finish Group

The first Vascular Task and Finish Group was held on 16th June 2020. There was good representation from multidisciplinary team members as well as patient and primary care presence. Terms of reference (Appendix 1) was reviewed and are submitted with this paper for approval. The action plan will be tracked through the group with regular updates provided to QSE via exception reporting.

External review of the vascular service

The Royal College of Surgeons will be invited to undertake an external, independent multi-disciplinary assessment of the service. The terms of reference for this review will be drafted by the Secondary Care Medical Director with the Community Health Council (CHC) and patient and carer representatives and this will be brought back to the next meeting.

North Wales Vascular Network Action Plan - Progress against actions within the Vascular Network Action Plan (Appendix 2):

Alignment of vascular inpatient bed base

A review of the capacity and demand for inpatient beds across the service was presented. Further work is required how to understand how the bed base across the Health Board should be distributed whilst ensuring capacity in Glan Clwyd Hospital for major arterial work. It was agreed that the alignment of beds needs to be incorporated into the patient pathway work streams. The lower limb service continues to be delivered across all sites with local access to consultant and MDT review.

Pathways of care

It was agreed that the resource, project leads and time frames for development of pathways would be discussed in the Task and Finish Group and the Clinical Advisory Group (CAG) would provide scrutiny of the pathway. CAG have agreed to facilitate the progress of vascular pathways. There has been progress

on the development of pathways highlighted by the service review in relation to the pathway for patients that use drugs intravenously presenting with groin abscesses and for patients post major arterial surgery requiring rehabilitation. The non-arterial diabetic foot pathway requires project management support due to the breadth and complexity of this pathway. Expressions of interest for a clinical lead will shortly be sent out by the Secondary Care Medical Director.

Engagement and Communication

Progress to develop a stakeholder engagement plan (Appendix 3) was presented by the Head of Patient Experience in order to maximize opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will link to the Health Board's Listening and learning group. It was agreed that there will be a shared approach with the CHC with patient/carer representation to progress this and explore options for a collaborative approach. There is a review of patient reported outcome measures (PROM) and patient reported experience measures (PREM) in conjunction with existing patient experience data, together with a focus on receiving real time feedback from inpatient and outpatient settings across all sites. Patient information will now be reviewed and developed with the support of the corporate patient experience team and service user involvement through the CHC.

Quality and Safety

A baseline safety culture survey using the Manchester Patient Safety Framework will be undertaken to inform areas for improvement. This will help the service understand their level of development with respect to the value that they place on patient safety.

A draft vascular dashboard was presented to the Task and Finish Group which has been developed to provide assurance of service performance, displaying key metrics and performance indicators. It is aligned to corporate dashboards, and supports the triangulation of complaints, incidents, compliments and lessons learnt trends. This dashboard also provides performance monitoring and includes theatre utilisation, outpatient activity and Referral to Treatment Time and the follow up waiting list, inpatients and outliers, and mortality.

Access to the Service

Further work is required to reduce waiting times and manage the follow up backlog. Recovery plans will continue to require monitoring to ensure improvement. The vascular activity will be separated from general surgery for reporting purposes and a separate report for vascular will be shared via secondary to the Planned Care Improvement Group for future assurance.

The next meeting of the Task and Finish Group will take place on 17th July.

Financial Implications

The scope of this report does not include financial implications.

Risk Analysis

Risk assessments will be undertaken as part of the governance of the Task and Finish Group. A risk register relating to the action plan will be included in the Task and Finish Agenda and be highlighted in the exception report.

Legal and Compliance

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

Board and Committee Report Template V1.0 December 2019.docx

Betsi Cadwaladr University Health Board

TERMS OF REFERENCE - DRAFT

Vascular Network Task and Finish Group

Accountability	Quality, Safety and Experience Committee
Remit	The Vascular Network Task and Finish Group will be responsible for implementing the recommendations identified in the Review of the North Wales Vascular Network presented to the Health Board in May 2020. ***The CHC has compiled a report following a series of engagement events with the public and staff. This group will also address any areas for improvement raised within the CHC report.*** The principle objective of the review was to assess the impact of the vascular services provided across the North Wales network and incorporated the following: a) A review of the current provision and delivery of vascular surgery services in North Wales following the implementation of a centralised service in April 2019. b) The safety and accessibility of vascular services for all patients receiving care from the North Wales Vascular Network. c) The risk management and clinical governance arrangements of the North Wales Vascular Network. d) To identify lessons that can be learnt: both examples of good practice and areas where improvement is required e) Clear recommendations for the consideration of the Health Board as to possible courses of action which may be taken to address any specific areas of concern which have been identified. The group will ensure that all relevant stakeholders with a responsibility for planning and delivering services have an opportunity to review/discuss pertinent

	issues and agree an achievable work plan for delivery of the recommendations. These will include clinical facilities, service delivery, scheduling and risk management issues as well as finance and performance.
Chair	Executive Medical Director
Core Membership	• Secondary Care Medical Director • Executive Nurse Director • Nominated Hospital Director • Clinical Director Vascular Network • Nominated Hospital Medical Director • Nominated Hospital Nurse Director • Chair of the Clinical Effectiveness committee • Primary Care clinician • Consultant Anaesthetist/Critical Care • Clinical Lead for Interventional Radiology • Vascular Network Manager • Community Health Council Representative • Vascular patient and carer representatives • Therapies representative • Communications • Corporate Patients Experience Lead • Informatics • Other members will be co-opted as required and the group develops
Administrative Support	Action log
Attendance	Any clinician, manager or nurse who is not a core member of the group may be asked to attend to discuss specific agenda items within their area of responsibility
Quorum	Greater than five members including the Chair or Vice Chair (Executive Nurse Director) one of which must be in attendance.
Frequency & Venue	Monthly
Proposed Start Date	June 2020
Authority	Quality, Safety and Experience Committee

Functions	The work of the Group will address the recommendations from the finalised action plan**:** • Alignment of vascular inpatient bed base • Pathways of care • Engagement and communication • Quality and Safety • Access to the service
Outputs	An up to date action log will be maintained and circulated to agreed stakeholders after each meeting. The Group will provide a monthly report to the Quality, Safety and Experience Committee.
Reporting	The Chair may raise specific matters at the meeting for information, discussion or approval. All members may submit items for discussion to be brought to the meeting. Agenda and supporting papers will be circulated one week prior to the meeting. The Group will provide a monthly report to the Quality, Safety and Experience Committee.
Communication	Each member has a role that involves communicating and disseminating information.
Escalation	Escalation of issues to the Quality, Safety and Experience Committee

Draft Vascular Service Improvement Plan

Recommendation	DRAFT ACTION	Suggested lead	When
Alignment of vascular inpatient bed base	• Review of the capacity and demand for inpatient beds across the service. • Continued delivery of the lower limb service across all sites with local access to consultant and MDT review.	Vascular Manager	16/06/20 16/06/20
Pathways of care	• Develop the non-arterial diabetic foot pathway consistent with National Diabetic Foot Pathway and NICE guidelines • Review and refine angioplasty pathway • Review and refine pathways for patients that use drugs intravenously presenting with groin abscesses • Review and refine pathway for patients post major arterial surgery requiring rehabilitation	Clinical Advisory Group Clinical Advisory Group Clinical Advisory Group Clinical Advisory Group	16/6/20 16/6/20 16/6/20 16/6/20

	• Refine and review pathway for non-surgical arterial condition for 'palliative' patients, in conjunction with palliative care team	Clinical Advisory Group	16/6/20
Engagement and communication	• Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Comms lead	16/6/20
	• Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	Secondary Care Nurse Director	Review at all meetings of Vascular Task and Finish Group
	• Review opportunities for staff to speak and feel able to raise concerns, including Safe Haven arrangements	Executive Medical Director	October 2020
	• Development of a stakeholder engagement plan to maximize opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will	Corporate Lead for Patient Experience	16/6/20

	link to the Health Board's Listening and learning group		
	• Review of PROM/PREM measures to improve patient experience alongside existing patient experience data	Corporate Lead for Patient Experience	16/6/20
	• Review of patient information and accessibility (including travel) with the support of the patient experience team	Corporate Lead for Patient Experience	16/6/20
Quality and Safety	• Baseline Safety culture survey to be undertaken to inform areas for improvement.	Corporate Quality lead	16/6/2020
	• Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	Corporate Quality lead	July 2020
	• Explore the potential to work with a high reporting service to share good practice	Corporate quality lead	16/5/2020
	• Development of quality and safety E-Dashboard, aligned to corporate dashboards, triangulation of complaints, incidents, compliments and lessons learnt trends to provide assurance from ward to board.	Corporate Improvement Team	July 2020

	• Develop key workforce indicators to provide assurance on the safety of the workforce, including escalation measures	Vascular network lead in partnership with Workforce lead	July 2020
	• Training Needs Analysis to be undertaken to support the emerging clinical pathways and future workforce model	Service clinical leads	August 2020
	• Issues of significance report from vascular Task and Finish group to Quality, Safety and Experience Committee	Chair of the T&F Group	16/06/20
	• Consider all opportunities for national/international benchmarking including the National Vascular Registry and national audits to assess, evaluate and review opportunities and improve the service	Chair of Clinical Effectiveness Committee	16/06/20, and review monthly
Access to the service	• Evaluate and report to Quality, Safety and Experience Committee compliance with agreed service implementation plans	Executive Medical Director	16/06/20

	• Monitor vascular waiting times • Reporting template and submission to be drafted by the Secondary Care leadership team and to be ratified.	Head of Planned Care Secondary Care Medical Director	16/06/20 16/6/20
This action plan will reviewed and updated at the first Task and Finish Group meeting on 16/06/20			

Vascular Task and Finish Group – actions and preparation for 16 June Meeting.

Aims: Engagement and communication:

Review of PROM/PREM measures to improve patient experience, in conjunction with existing patient experience data
Review of patient information and accessibility (including travel) with the support of the patient experience team

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes
PREMS				
1. Review secondary data relating to complaints, real-time feedback, care2shares and patient comments.	Exploratory Data Analysis to include, where possible, statistical comparison of Q1&Q2 2019/2020, compared with Q3&Q4 2019/2020. To include thematic comparison of qualitative feedback to identify any trends or inferences post and pre reconfiguration of vascular services. The methodology will use 'vascular speciality' to scope patients and location exact = Dulas YG and Ward 3 YGC.	PM and AD	2nd June	Completed  Review of secondary care com
2. Identify active outpatient clinics for the next 6 weeks.	Table of OPD clinics and contacts in order that Patient Experience Coordinators are able to approach staff to hand out questionnaires and/or use smart devices to collect the data.	JG	5th July	YG: Wed AM YGC: Wed PM WMH: Friday AM, Wednesday AM, Thursday AM
3. Review and if necessary amendment of patient feedback (PREMS) questionnaire. To include any additional items related to access to and coordination of the service identified as reported issues within the CHC report.	Validation of patient experience questionnaire. At the vascular task and finish group meeting meeting the request was discussed, requesting CHC and patient/carer representaion from the group to review our form. There was agreement from patient and carer representation present that it was of benefit to request via CHC.	PM	2nd June	Completed  Microsoft Word Document

Task/Action required	How Task will be achieved & Outomce	Responsible to	Current Status	
			By When	Progress update and notes
4. Utilise amended questionnaire in real time within active OPD and within Vascular Wards (3)	Real/Near Time from OPD clinics and vascular ward – where activity exists and access is possible[1] (*Data collection to commence 15th June – and coded and analysed 'manually' using coded template for weekly reporting*).	PM/PALS Officers AD/EY	15th June	YG Data Collection commenced within YGC and YG week beginning the 15/06/2020 weekly Excel Template developed for reporting.
5. Develop a sampling frame for retrospective audit of Vascular patients. Register as Tier III audit.	Agreed that Ward 3 YGC would be utilised in the first instance, and consenst obtained to participate within Care2Share interview prior to discharge and Datix PALS utilised to store and code the interviews.	JG/PM with support from IM&T	15h June	Participant information and consent form developed and shared with PALS officers and Patient Experience Managers.
6. Develop question stems for Care2Share in order to collect primary feedback in relation to the reported issues within the CHC report.	Tested Care2Share interview pro-forma	PM/PALS Officers	15th June	Participant Information Sheet developed by Summer Intern – PM/AD to validate. Share approach with CHC and patient represenative See Above
6a. Share Approach with CHC	Share approach with CHC and patient representation and explore options for a collaborative approach	PM/CO	Review date	CHC aware of the proposed approach and collaborative approach offered and explored operationally..
7.Utilise sampling frame to invite patients to take part in retrospective audit. (5, 6 & 6a))	Agree dates and time for care2share telephoned interviews. Utilise mailing list for patient experience survey. Additionally ensure that the survey is available on the internet.	PALS Officers	19th June	Documentation to be delivered to the Wards by 18th June 2020, and first interview to be undertaken by 25th June 2020. Request if CHC can support exploration.
8.Utilise a combination of care2share and/or amended patient experience survey to collect data. (7)	Retrospective review of patient experience for vascular patients using NHS Inpats Questionnaire – complete audit report and recommendations.	PM/PALS Officers	20th July	Request for sampling frame forwarded to IM&T – based on the same procedure as for INPATS

PROMS				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1.Determine if PROMS data set exist	Undertake analysis of PROMS data set for Varicose Veins. Incorporate into version 0.2 of patient experience report – see 1 above	PM	5th June	There are no PROMS data sets currently in existence within BCUHB.  RE Re Query around PROM - Vari
2.If PROMS data set does not exist – decide at what points in the pathway the ED5 questionnaire can be utilised (1)	Identify patient groups, and 2 points in the pathway or determine if it can be utilised post recovery for retrospective patients.	JG and nominated clinical leads	TBC following outcome of meeting on 24/06/20	Meeting with the chair of the clinical effectiveness group, secondary care medical director, vascular manager and clinical director on 24/06/20 to ensure effective collaboration
3. Develop protocol for administering PROMS Questionnaire (1 & 2)	Establish PROMs Data set for identified Vascular Patient Groups	JG and nominated clinical leads	TBC	Link with chair of the clinical effectiveness group to ensure effective collaboration. Meeting on 24/06/20.
PATIENT INFORMATION				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**

1. Website and leaflets	Scope information available on the internet/intranet to ascertain what information is presently available to patients in relation to their vascular procedures, literature etc. Contact the vascular clinics on sites to scope and identify all written information given to clinic attenders, and those discharged from the vascular wards. Scope what information is given to vascular patients following rehabilitation therapy (physio/ OT).	CO/JO	12th July	Initial review undertaken, 12th June. PT INFORMATIO LEAFLET SCOPE.docx 2nd stage required to identify information in use.
1a. Reviewing Written Information.	Ensure that CHC representation is mandated within the readers/review panel for Written Patient Information Guidance Policy ISUE01 explicitly states this.	CO/JO	12th July	Request CHC engagement to review revised guidance and review vascular health information samples.

Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1b Create Validated Library of Vascular Patient Information in line with ISUE01 policy guidlines	Pilot the reviewed procedures within ISUE01 by creating a Vascular Patient Information Library.	CO/JO	12th July	Engage with CHC to review,
2. Complaints	Repeat query used to compile information informing the Vascular report, for the period November 2019 to March 2020.	YW	25th June	

DASHBOARD				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**

3. Dashboard	The group discussed dashboards and shared information. JG has a meeting on 5 June and will forward any useful information after that.	JG	17th July	Full draft dashboard shared with Medical Director, Sec Care Medical Director, Patient Experience Lead and Clinical Director for comment. Presented to T&F on 16/06/20. Further developments in progress for presentation at July meeting
3a Dashboard and Performance Metrics	Agree Minimum Data set for Vascular dashboard and ensure that Patient Experience Data (legacy and prospective) is linked.	JG/PM/CO	20th July 2020	Work Stream needs to be aligned with PID1 and reported to the Concerns Management and Quality Systems Group (CMQSG) – PM/CO to report on progress at the 01/07/2020 meeting.

IMPROVEMENT PLAN – ENGAGEMENT & COMMUNICATION				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1. Communication Plan to be drafted with input from staff, CHC, service user representatives for presentation at the Vascular Task and Finish Group	Engagement plan developed which clearly identifies stakeholders, communication channels, purpose of communication and anticipated impact on proposed change, Engagement Plan to include clear frameworks and mechanisms for staff to raise a concern(s) taking into account the current policy trajectory.	CO	20th July 2020	CO to e-mail CHC to ensure representation, see also actions above relating to CHC review of patient information and care2share methodology. RC to scope – task initiated
2. Ensure any service change includes service user and carer involvement, and utilise patient feedback to inform improvement	Ensure that change framework includes a baseline evaluation of patient experience, a 'Voice of the Customer' type matrix and a post implementation evaluation of patient experience. PM to develop potential framework by the next Vascular Task & Finish Group	CO/JO	22nd July	Initial discussion in relation to proposed methodology, the utilisation of PREMs measures identified above pre and post change cited as essential.
3. Development of a stakeholder engagement plan to maximize opportunities to listen and learn from feedback, to include patient and carer engagement with the development of a virtual vascular patient and carer network which will link to the Health Board's Listening and learning group	See 1 & 2 above. Progress towards archivement of the aims and objectives of the engagement plan to monitored by the Listening and Learning Group (Patient Carer Group).	RC		

IMPROVEMENT PLAN – QUALITY & SAFETY				
Task/Action required	**How Task will be achieved & Outomce**	**Responsible to**	**Current Status**	
			By When	**Progress update and notes**
1. Baseline Safety culture survey to be undertaken to inform areas for improvement	Ensure that BCUHB has permission to utilise the Manchester Univesrity Pt Safety Evaluation framewok – although this should be open source as developed by the NPSA, and develop a framework for its application within BCUHB – to be reviewed at next Vascular Task & Finish Group Meeting.	JG/JWJ	22nd July 2020	
2. Benchmarking of service incident reporting to improve safety via an open incident reporting culture and improve learning	Secondary data analysis of Complaints and Incidents in relation to lessons learnt for specialy='Vascular' and identify any trends in relation to training and/or service improvement. Plan for introducing You Said/We Did to Incidents & Complaints – development of SOP, using PALS You Said/We Did Pro-fomra	CO/YW CO/JWJ	22nd July 2020 TBD	
3. Review Service Risk Register	Complete review of risks and controls, determine if controls are adequate, identify any further service developments or training which is required to reduce the mitigated risk score further and/or to remove the risk from the register.	MJ and CO to work with JG	TBD	

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Annual Assurance Report on compliance with Nurse Staffing Levels (Wales) Act
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy Chief Executive / Executive Director of Nursing & Midwifery
Awdur yr Adroddiad Report Author:	Debra Hickman, Secondary Care Nurse Director
Craffu blaenorol: Prior Scrutiny:	The designated person has the responsibility of presenting an Annual Assurance report to the Board. Staffing Breaches and Harms are reported quarterly via the Secondary Care Quality and Safety group by each Site Director of Nursing, escalation of significant issues are reported via QSG. The following summary report has also been presented to QSG.
Atodiadau Appendices:	*1.* Summary of Required Calculated Establishment

Argymhelliad / Recommendation:

Note the report.

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

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

Sefyllfa / Situation:

To 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 provide sufficient Nurses to provide timely and sensitive care to patients. The Executive Director for Nursing and Midwifery as Executive lead has delegated the operational activity via the Secondary Care Nurse Director for the identified Medical & Surgical Inpatient wards within the Act. As part of the triangulated approach consideration is given to those quality indicators that are particularly sensitive to care provided by a Nurse: Patient falls, Pressure Ulcers, Medication errors and Complaints associated to Nurse staffing and Nursing care as provided in the Assurance report within.

Asesiad / Assessment & Analysis

Strategy Implications

Inability to provide appropriate Nurse staffing levels to ensure time to care for patients sensitively can compromise the Health Boards ability to deliver Health Care effectively.

Financial Implications

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.

Risk Analysis

The governance issues are:

- the current vacancy position and its impact on ward included in section 25B
- the impact of the COVID pandemic and the changes of ward profile to meet the COVID demand
- any instances whereby investigations identify staffing deficits
- due to delay in acuity audits being undertaken as directed by the CNO this may also impact on the presentation to the Board on the recalculation of the nurse staffing levels for 2020.

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.

Impact Assessment

Undertaken as part of the Biannual calculations

	Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act
Health board	Betsi Cadwaladr University Health Board
Date annual assurance report with compliance with the Nurse Staffing Levels (Wales) Act is presented to Board	July 2020
Reporting period **Requirements of Section 25A** Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels **in any area where nursing services are provided or commissioned, not only adult medical and surgical wards.**	6th April 2019 – 5th April 2020 The Health Board under section 25a of the Nurse Staffing Levels (Wales) Act 2016 has an overarching responsibility to provide sufficient Nurses to provide timely and sensitive care to patients. The Executive Director for Nursing and Midwifery as Executive lead has delegated the operational activity via the Secondary Care Nurse Director for the identified Medical & Surgical Inpatient wards within the Act with annual reports provided to the designated Committee. In addition to the wards for where Section 25B of the Act applies a series of reviews have also commenced in areas where nursing services are applied/commissioned which include: • Outpatient departments • Admission portals • Critical care / High dependency units • Theatre areas • Procedural units • Day case areas • Rehabilitation areas Although the above areas do not fall directly under the auspice of section 25B, a structured and triangulated approach has been applied to calculate and inform the nurse staffing levels required for each area and to ensure consistency of approach. Consideration of National Guidelines regards Nurse staffing levels for each speciality, specific Nurse sensitive indicators that may be relevant and professional judgment will form the basis of the triangulated approach.

Actions taken in relation to calculating the nurse staffing level on section 25B wards during the reporting period. • **Adult acute <u>medical</u> inpatient wards** • **Adult acute <u>surgical</u> inpatient wards** (Ref: paragraph 26-30)	To assure compliance with the Act, a series of activities are undertaken of which include the following: • Nurse rosters are developed to ensure the effective use of Nursing resource utilising electronic systems for efficiency and consistency • Staffing is reviewed on a daily shift by shift basis utilising patient acuity / demand and professional judgment with all mitigations / decisions recorded as per HB Nurse Staffing Policy • A Biannual review of Nurse Staffing - this process combine's acuity and dependency data applying the Welsh Levels of Care as the means of assessment alongside key Nurse Sensitive Indicators and Professional Judgement to determine the required establishment to meet the care needs for the patients in each Acute Adult Medical and Surgical Inpatient ward. • Workforce requirements are reviewed on Annual basis in line with current and future site and Health Board wide strategies or whereby there is a change in ward profile. Training and Education requirements are commissioned in line with both Site and HB wide strategies to develop and secure a nursing workforce that is equipped for both service and patient needs. • Utilisation of workforce profiling data ensures the appropriate level of focus on recruitment and retention including forward planning and maximising resource and opportunities Of which are described in more detail below. The process for determining the Nurse staffing levels at Betsi Cadwaladr University Health Board has three steps: 1. Acuity and dependency data is collected for a full month for all wards falling under the concern of the Act. This data is reviewed and validated via the Senior Nurse teams. 2. Upon completion and publication, this data is utilised as part of a triangulated method at local Ward reviews. The triangulation includes the review of a range of Nurse Sensitive Indicators, Professional Judgement using the Chief Nursing Officers guiding principles. The local review meetings are multi-disciplinary and consider factors such as escalation beds, increases in demand and activity and national focus. 3. A recommendation for the planned staffing establishment for each ward is concluded. The Hospital Nurse Director verifies this with proposed changes being notified to the designated Secondary Care Nurse Director prior to final approval by the Executive Director for Nursing and Midwifery. For audit purposes, each ward completes the designated proforma available within the 'Nurse Staffing levels (Wales) Act 2016' Operational Guidance as evidence. Following the above process, the outcome of the above review was presented to QSE as the designated receiving committee in November 2019, the detailed nurse staffing for each of the designated wards at that time, together with the rationale and the committee received recommendations.

Using the triangulated approach to calculate the nurse staffing level on section 25B wards (Ref: paragraph 31-45)	The Triangulated approach as prescribed in the Nurse Staffing Levels (Wales) Act 2016 is utilised across the HB for the calculation of nurse staffing levels for wards designated in section 25B, this forms part of the HBs Nurse Staffing policy and underpins the work undertaken on a bi-annual basis. The Nurse Staffing policy was audited in 2019, whereby several recommendations were made to strengthen the process of calculation and reporting, all of which have now been addressed and completed.
Informing patients (Ref: paragraph 20-25)	Information whiteboards display the planned safe staffing requirements at the entry of each ward. These are audited as part of the HBs Ward Accreditation process. Patients have access to bilingual Frequently Asked Questions information leaflets, which includes how to raise concerns about the Nurse Staffing Levels.
	Section 25E (2a) Extent to which the nurse staffing levels are maintained
The extent to which the nurse staffing levels have been maintained (Ref: paragraph 13-19)	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 have been working, 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 have been maintained in areas, which are covered by Section 25B/C of the Act For the 2019/20 Annual report, this Health Board - together with all other Health Boards/Trusts in Wales - is providing 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. For the 2020/21 reporting period, it is anticipated that this section of the Annual report will contain quantitative data for part of the year at least. This data, once available for every Health Board in Wales, will be presented collectively in a consistent manner. Staffing is reviewed on a daily, shift-by-shift basis by the Senior Nursing teams within each of the Acute Sites, all actions / mitigations are recorded in the electronic rostering system. Whereby any consideration of harm because of staffing breaches, these are reported via the HB’s incident reporting system – Datix. As part of the Workforce efficiency streams, ongoing reviews / monitoring have been implemented regards roster and nurse staffing deployment efficiencies, supported by key metrics.

	New opportunities have been further embedded across the Health Board expanding opportunities for home grown Nurse Registrants. A focus on preceptorship programmes for our Newly Qualified staff to aid and support their development and career within the Health Board has received positive feedback. However, we cannot overlook the ongoing challenge regards to Nurse vacancies and the continued efforts regards recruitment and retention.
Process for maintaining the nurse staffing level (Ref: paragraph 13-19)	The process for maintaining safe Nurse staffing levels are supported by a number of elements of which include: • Adult Acute Nurse staffing and Nurse staffing escalation policies are in place and accessible online for staff to refer to • 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 • Roster approval process – all nurse rosters are subject to a double approval process monitored by the senior nurse 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 • Streamlined fast track recruitment for internal staff • Centralised recruitment team to support campaigns for Nurse recruitment • Partnership working with local universities to maximise opportunities for recruitment and retention • New Role developments

((Ref: paragraph 43-44)	Section 25E (2b) Impact on care due to not maintaining the nurse staffing levels														
Patient harm incidents (i.e. nurse-sensitive Serious Incidents /Complaints)	**1) Total number of closed serious incidents/complaints during last reporting period**			**2) Total number of closed serious incidents/complaints during current reporting period.**			**3) Total number of serious incidents/complaints not closed and to be reported on/during the next reporting period**			**4) Increase/decrease) in the number of closed serious incidents/complaints between reporting periods**			**5) Number of serious incidents/complaints where failure to maintain the nurse staffing level was considered to have been a factor**		
Hospital acquired pressure damage (grade 3, 4 and unstageable).	YWM 37	YG 31	YGC 16	YWM 22	YG 7	YGC 25	YWM 0	YG 1	YGC 0	YWM Decrease of 15	YG Decrease of 24	YGC Increase of 9	YWM 0	YG 0	YGC 0
Falls resulting in serious harm or death (i.e. level 4 and 5 incidents).	YWM 14	YG 25	YGC 16	YWM 13	YG 18	YGC 10	YWM 0	YG 1	YGC 0	YWM Decrease of 1	YG Decrease of 7	YGC Decrease of 6	YWM 0	YG 0	YGC 0
Medication related never events.	YWM 0	YG 3	YGC 1	YWM 0	YG 0	YGC 0	YWM 0	YG 0	YGC 0	YWM Static	YG Decrease of 3	YGC Decrease of 1	YWM 0	YG 0	YGC 0
Complaints about nursing care	YWM n/a	YG n/a	YGC n/a	YWM 3	YG 0	YGC 2	YWM 0	YG 1	YGC 0	YWM n/a	YG n/a	YGC n/a	YWM 0	YG 0	YGC 0

Section 25E (2c) Actions taken if the nurse staffing level is not maintained	
Actions taken when the nurse staffing level was not maintained	• 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
Conclusion & Recommendations	
	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 is ongoing. There is continual development 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 Board are asked to note and support the following next steps: • Targeted focus of Nurse recruitment including resource to support campaigns both locally and regionally • Exploration of a clinical fellowship programme for nurses • Ongoing analytics regards leavers and 'what could we do better?' • Review of implementation of new roles to support the nursing recruitment pipeline • Expansion of harm avoidance collaborative to assist in reducing variation • Development of a nurse performance dashboard as a further monitoring and assurance tool in real time • Further analysis of deviations from previous reporting periods

Appendix: Summary of Required Establishment – see attachment

Appendix: Summary of Required Establishment
Betsi Cadwaladr University Health Board

Health board/trust:	Name: Betsi Cadwalader UHB	
Period reviewed:	Start Date: 1st of April 2019	End Date: 31st of March 2020
Number of wards where section 25B applies:	**Medical:**	**Surgical:**
	Number: YG 7 YGC 8 YWM 9	**Number: YG 4 YGC 5 YWM 4**

To be completed f EVERY wards where section 25B applies

***Supernumerary i.e. 1 WTE supernumerary ward sister/charge nurse included in the establishment**

YG Medical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Aran	22.62	14.11	Partially	22.62	14.11	Partially	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward repurposed as a COVID-19 ward 2-4-20
Glyder	13.49	8.01	Yes	13.49	8.01	Partially	In part	No	January calculation deferred due to COVID-19	No	No	
Glaslyn	16.82	22.62	Yes	16.82	22.62	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Hebog	24.96	11.42	Yes	24.96	11.42	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Prysor	12.77	8.51	Yes	12.77	8.51	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Moelwyn	22.62	8.51	Partially	22.62	8.51	Partially	In part	No	January calculation deferred due to COVID-19	No	No	

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Tryfan	17.71	8.51	Partially	17.71	8.51	Partially	In part	No	January calculation deferred due to COVID-19	No	No	

YG Surgical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Dulas	21.5	14.78	Yes	21.5	14.78	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward repurposed as a COVID-19 ward 2-4-20
Enlli	12.54	7.3	Partially	12.54	7.3	Partially	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward re purposed as a COVID 19 critical care area – step down – CPAP patients. Staff are deployed from critical care and other areas of the site dependant on need 2-4-20 base establishment maintained
Ogwen	16.13	21.5	Partially	16.13	21.5	Partially	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward repurposed as a COVID-19 ward 6-4-20
Tegid	26.89	18.82	Yes	26.89	18.82	Partially	In part	No	January calculation deferred due to COVID-19	Yes	No	To enable a shift pattern to meet the needs of the ward and to provide patients and staff with safe mitigation of risk the following is recommended: The permanent change of roster template for Tegid ward to introduce an AP shift Monday to Friday and 5 HCA on a

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
												weekend instead of the 6th trained.

YGC Medical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 1	18.53	16.01	Yes	18.53	17.93	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	9/4/20 S.25B ward repurposed due to COVID-19 21/5/20 Returned to S.25B ward Uplift in HCSW initiated in 2019 establishment review
Ward 2	18.53	16.01	Yes	18.53	17.93	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	9/4/20 S.25B ward repurposed due to COVID-19 21/5/20 Returned to S.25B ward. Uplift in HCSW initiated in 2019 establishment review
Ward 4	18.53	15.01	Yes	18.53	15.01		In part	No	January calculation deferred due to COVID-19	No	No	
Ward 9	18.53	15.01	Yes	18.53	16.71	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	26/3/20 S.25B ward repurposed due to COVID-19 Uplift in HCSW initiated in 2019 establishment
Ward 11	24.33	13.64	Yes	24.33	16.71	Yes	In part	Yes	January calculation	Yes	Yes	12/3/20 Ward became positive COVID respiratory ward. To include admission area for patients requiring NIV / CPAP.

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
									deferred due to COVID-19			HCSW increased to support COVID acuity.
Ward 12	18.53	15.01	Yes	18.53	17.62	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	14/3/20 S.25B ward repurposed due to COVID-19 Uplift in HCSW initiated in 2019 establishment review.
Ward 14	24.33	10.91	Yes	24.33	14.09	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Ward remains a S.25B adult medical ward. Uplift in HCSW initiated in 2019 establishment review.
Ward 19	18.53	19.88	Yes	18.53	19.88	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	

YGC Surgical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Ward 3	19.81	9.2	Yes	19.81	10.54	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Ward remains an S.25B Adult Surgical Ward This ward forms part of site COVID escalation plan and has the potential to be escalated to 23 beds. Uplift in HCSW initiated following establishment review March 2020.
Ward 5	24.33	16.49	Yes	24.33	16.49	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	17/4/20 S.25B ward repurposed due to COVID 19 18/5/20 Return S.25B Adult Surgical Ward
Ward 7	24.07	22.92	Yes	24.07	22.92	Yes	In part	No	January calculation deferred due to COVID-19	No	No	
Ward 8	18.53	15.01	Yes	18.53	15.01	Yes	In part	Yes	January calculation deferred due to COVID-19	No	No	
Ward 6 ABH	23.29	9.43	Yes	23.29	9.43	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	17/3/20 Ward closed as elective orthopaedic service suspended on the YGC site as part of COVID preparation plan. All staff redeployed to YGC adult acute wards and departments.

YWM Medical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Morris	18.91	13.63	Yes	16.35	18.55	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Based on 21 beds – previously funded at 27 beds.. HCSW dependency increased due to nature of patient cohort. RN reviewed at night in line with CNO for 21 pts. (Budget confirmed 11/05/2020)
Mason	18.91	13.63	Yes	18.91	14.76	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Currently suspected pts COVID-19 ward – based on Erddig Ward template. No changes required due to acuity & dependency of patients. Agreed at establishment review. Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
Evington	15.18	12.63	Yes	15.18	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Establishment based on 21 beds (Budget confirmed 11/05/2020)
Erddig	24.02	12.4	Yes	24.02	16.09	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Establishment reviewed for COVID-19 high care CPAP area – based on POW template currently. No adjustment needed due to acuity of patients – CPAP/NIV Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
Cunliffe	18.91	12.3	Yes	18.91	12.3	Yes	In part	No	January calculation deferred due to COVID-19	No	No	

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Bromfield	10.23	4.92	Yes			Yes	In part	NA	January calculation deferred due to COVID-19	NA	NA	N.B Currently Bromfield not in use as Act Ward due to COVID-19. Staff supporting COVID-19 areas.
Bersham	18.91	8.71	Yes	24.02	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Increase for RN acuity. Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
ACU	29.14	7.38	Yes	29.14	12.30	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
Bonney COVID-19 (Arrivals staff)	22.74	16.4	Yes			Yes	In part	NA	January calculation deferred due to COVID-19	Yes	Yes	Repurposed as COVID-19 to support Women's Services Pathway. Staffing allocated accordingly from Arrivals staff but not fully funded complement for inpatient area 24/7. Supplemented from staffing from other areas.

YWM Surgical

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Fleming ward 23 funded	20.69	10.02	Yes	29.43	17.40	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing assessment x 2 in 2019/20 Increase in beds from 23 to 29 funded surgical beds and noted increase in acuity following ward reconfiguration
ENT ward 19 funded	16.01	12.05	Yes	15.21	11.93	Yes	In part	Yes	January calculation deferred due to COVID-19	NA	Yes	Completed assessment of staffing establishment x2 Decrease in HCA as budget covered ENT ward and ENT clinic. Completed assessment of staffing establishment x2
Pantomime ward 29 funded	23.74	18.25	Yes	23.74	21.13	Yes	In part	Yes	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing establishment x2 Increase in HCA to support activity on night duty for assessment unit

Ward	Required Establishment at the start of the reporting period (April 2019)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the start of the reporting period?*	Required Establishment at the end of the reporting period (April 2020)		Is the Senior Sister/Charge Nurse supernumerary to the required establishment at the end of the reporting period?*	Biannual calculation cycle reviews, and reasons for any changes made			Any reviews outside of biannual calculation, if yes, reasons for any changes made		
	RN WTE	HCSW WTE		RN WTE	HCSW WTE		Completed	Changed	Rationale	Completed	Changed	Rationale
Prince of Wales ward 21 funded	16.01	12.05	Yes	15.21	11.93	Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing establishment x2 decrease in HCA and R/N as staffing reduced at weekend
Prince of Wales ward 27 funded On Pantomime ward template for COVID19			Yes			Yes	In part	No	January calculation deferred due to COVID-19	Yes	Yes	Completed assessment of staffing establishment x2 COVID Ward and increase from 21 to 27 beds (6 extra beds no funding but staff levels added) Currently elective orthopaedic ward closed but staff have moved to Pantomime ward template to cover a COVID 19 ward and therefore staffing for this ward does not normally reflect the funded 21 bed for POW. Gaps in the day having to be covered from other clinical areas from medicine and surgery. Decrease in HCA and R/N as staffing reduced at weekend.

Cyfarfod a dyddiad: Meeting and date:	**Quality, Safety and Experience Committee 3.7.20**
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Nursing Workforce
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing & Midwifery
Awdur yr Adroddiad Report Author:	Debra Hickman, Secondary Care Nurse Director
Craffu blaenorol: Prior Scrutiny:	Senior Nurse Group
Atodiadau Appendices:	*Appendix 1 – CNO letter* *Appendix 2 – Section 25B ward profiles and Nurse Staffing levels* *Appendix 3 – Clinical Model*

Argymhelliad / Recommendation:

Recommendations

Acknowledge the report and assurance regards the escalation triggers and receive further reports should the need arise to vary Nurse Staffing levels from those previously reported.

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

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

Sefyllfa / Situation:

The Global pandemic of Coronavirus disease (COVID 19) has seen unprecedented affected patient numbers rise in recent weeks, requiring varying levels of treatment, be it invasive or supportive, of which has exceeded occupancy of our routine capacity. To provide for this increased need based on analysis of modelling data, additional nursing resource has been required. This paper describes the approach taken to maintain staffing levels across the Health Board being cognoscente of the impact on the Nurse Staffing Levels (Wales) Act 2016 during these unprecedented times. That said there is both a Professional and Legislative requirement for safe, effective, compassionate and dignified care as governed by the NHS Framework and Health Inspectorate Wales.

Cefndir / Background:

In accordance with the Nurse Staffing Levels (Wales) Act 2016, Nurse staffing levels for Wards under the auspice of section 25B of the Act are presented to the HB annually via a presentation from the Executive Nurse Director. These are derived through a rigorous triangulated methodology, which is set out in the Act, which include reviewing patient acuity, service activity & capacity, reported harms and Professional judgment. This encompasses the location, the specialist interventions required and the layout of such clinical areas to ensure that care can be delivered

appropriately and safely, as a Health Board we remain committed to this approach. We know from national data and emerging evidence alongside local intelligence that COVID19 patients are extremely sick requiring significant care and invasive treatment that is protracted in nature. From modelling data published by PHW we are also aware that radical plans are required to meet the numbers predicted to be affected by this pandemic, which provides an added tension to existing nurse staffing challenges.

Asesiad / Assessment & Analysis

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

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

Critical Care units

The Critical Care Nurse staffing model across the 3 Acute sites remains based on a 1:1 Nurse to Patient ratio in line with National Guidance. The escalation plan detailed in the report outlines the mitigation required to allow restructuring of critical care staffing levels to meet increased capacity as specified in https://gov.wales/coronavirus-increasing-adult-critical-care-nursing-workforce

Emergency Department (ED)

The ED Nurse staffing models having recently been reviewed externally and remain supported by national guidance. The escalation plan outlines proposals for adjusting and restructuring the ED staffing levels in line with the activity demand.

Adult Inpatient surgical / medical wards

Although the formal Spring 2020 staffing review has been suspended, all of the section 25B wards have been reviewed in the light of potential COVID impact and changes to the ward specialty for surge preparation. Therefore, a tabletop review was conducted with the Site Directors of Nursing and the respective Heads of Nursing for each of the acute sites and specialties within, triangulating capacity alongside acuity and defined Nurse Sensitive indicators for falls, hospital acquired pressure ulcers and medication incidents. This has been a dynamic process from March 2020 onwards and continues in light of the changing pandemic impact. The Nurse staffing levels are recorded in appendix 2.

Covid – 19 repurposed wards

A review of the modelling data published by PHW provided the basis for a baseline calculation of

Nurse staffing levels as described for the Adult Inpatient Medical and Surgical wards by the designated officer and subsequently approved by the Executive Nurse Director. The staffing levels were based on Professional Judgment and at a point in time. As data emerges regarding the current levels of demand and acuity presenting, these will continue to be reviewed dynamically, also considering other evidence and intelligence from around the world. The staffing assurance reports continue to be monitored through the existing governance routes as previously reported.

Field Hospitals

Additional emergency capacity has been developed across North Wales in conjunction with partner organisations using a range of private and public venues to support increased need should it arise in line with the modelling data from PHW. The Nursing workforce establishments have been calculated based on potential demand and the agreed Clinical Model for the Health Board. This has required a degree of fluidity due to the ongoing modelling discussions and resource availability that affect specific pathways e.g. oxygen availability, these factors also influence the skills sets required within these facilities.

Community services

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

- Suspension of non-essential contacts & visits
- Discharge hubs developed in each Health Community
- Review of community hospital function in line with the clinical model
- Collaboration with Care homes to support seamless pathway and transition

Mental Health Services

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

Paediatric Services

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

All of the above staffing levels will be determined in line with the levels of care determined in the Health Boards clinical model (appendix 3).

Maintaining the Nurse Staffing levels

The Health Board has an overarching duty under section 25A of the Nurse Staffing Levels Act (Wales) 2016 to provide sufficient Nurses within its services and commissioned services to allow

time to care for patients sensitively. However, in these unprecedented times it is acknowledged in the CNO's letter (appendix 1) that maintaining Nurse staffing levels will be a challenge and it is the responsibility of the Executive Nurse Director to minimise risks to Patient Safety. Professional judgment remains the responsibility within the Nursing hierarchy to mitigate risk, taking reasonable steps in maintaining the Nurse staffing levels as directed for the wards within section 25B (appendix 2). It is important to note that varying from calculated Nurse staffing levels alone does not constitute non-compliance with the Act.

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

Actions

1. Recruitment of Registered Nurses, including additions to the temporary COVID register of preexisting registrants and 3rd year Student Nurses into existing vacancies and fixed term additional contracts
2. Recruitment of HCSW's including 2nd year Student Nurses into existing vacancies and fixed term contracts
3. Back to the floor training for registrants requiring refresher training
4. Upskilling of registrants in critical care training and NIV training
5. Creation of a deployment dashboard to give high level overview of available staff/skills sets
6. Update to Nurse Staffing policy to include HB wide deployment escalation
7. HB policy review of scopes and competencies for certain Nursing tasks
8. Training of certain staff groups to allow extended tasks in line with Nationally supported competencies
9. Redeployment in line with care levels outlined in appendix 3

Escalation plans

Consideration of the Pandemic modelling data that has been assimilated to North Wales demographics consideration has been given to the Nurse staffing requirements and it is recognised that to meet the predicted demands significant variation from that of previously planned Nurse staffing levels that the Board would have been informed of current requirements.

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

Nurse staffing levels of this nature would be implemented when key triggers have been reached as defined in the Nurse staffing Mitigation plans for both Area and Acute sites as approved by the Executive Nurse Director. The decision to implement would be on the agreement of the Health Board as informed by the Executive Nurse Director via the Nurse staffing escalation route set out in the Health Boards Nurse Staffing policy.

Acute sites triggers would include:

- ventilation capacity – mechanical and non-invasive
- surge in ED demand

Health Board wide triggers would include:

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

Mitigations include:

- Deployment of staff on a risk assessed basis following workforce review and skills sets as part of COVID planning & preparation by the Nurse Directors
- Deployment of increased support and volunteers to undertake non-essential Nursing duties
- Deployment of enhanced support utilising Band 4 roles undertaking extended duties on a competency assessed basis
- Competency assessed deployment for high intervention areas such as Critical Care and ED
- Online specialty guides for redeployed staff
- Training for Donning and Doffing
- Fit testing Programme for clinical staff

Reporting Nurse staffing levels:

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

- Acuity audits maybe delayed or deferred due to COVID
- Deferment of the Annual Nurse staffing report due May 2020
- Acknowledgement that the deferral of the above Acuity Audit and Annual report will also impact the 3yr Implementation summary due Spring 2021
- Repurposed COVID wards due to the Pandemic were not subject to the prescribed triangulated approach
- Professional judgment as designated persons is a key determinant in ensuring nurse staffing in all areas is managed as appropriately as possible during an extraordinarily difficult time

There is an expectation from WG that the Acuity Audit will now take place in July 2020 of which the Executive Nurse Directors are planning for this to be undertaken, culminating in a presentation of the Annual report of the Nurse Staffing levels thereafter as reasonably possible.

Strategy Implications

Safe Nurse staffing levels impacts all elements of the HB Strategy aims

Financial Implications

COVID – 19 plan

Risk Analysis

Legal and Compliance

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

Impact Assessment

As above

Appendices – see attached

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

Llywodraeth Cymru
Welsh Government

To: NHS Executive Nurse Directors

24 March 2020

Dear Colleagues,

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

As COVID19 has become an established and significant epidemic across the UK, NHS Wales' staff and services are coming under increasingly extreme pressure. Welsh Government is fully aware that any sense of "*business-as-usual*" is becoming increasingly untenable.

I want to provide you with clarity and assurances around how I expect these additional pressures will disrupt the business-as-usual processes of - and work-streams associated with - the Nurse Staffing Levels (Wales) Act 2016 (*the Act*).

It will be helpful to consider the effects of the COVID19 pressures under two headings: firstly the ongoing work to extend the Act's second duty to paediatric inpatient wards; and secondly, compliance with and reporting against the existing duties under the Act.

Extending the second duty to Paediatrics

Thus far, the provisional schedule for this work has been as follows:

- June to August 2020: 3 month public consultation on the draft regulations and amended statutory guidance;
- November 2020: regulations laid before the Senedd;
- December 2020: Senedd debate and presumptive passing of regs;
- April 2021: Coming-into-force date of regulations on paediatric inpatient wards.

The timetable of those processes is now clearly compromised. In terms of the legislative steps, the capacity to undertake the drafting requirements is still available within Welsh Government. We intend to reschedule the plenary debate to February 2021, allowing the consultation to take place later in 2020, several months after the projected peak of COVID19 activity.

The remaining issue is the capacity within the health boards to take the necessary actions to prepare their wards and staff for the introduction of the new regulations. April 2021 now appears to be entirely unfeasible as a coming-into-force date. Given the current timescales, it is a fair assumption that health boards will require approximately 12 months of preparation time under normal circumstances before the regulations could come into force. In the context of this work stream, I consider *normal circumstances* to be suspended.

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However a final decision on a coming-into-force date won't need to be made until the regulations are laid before the Senedd in early 2021. We will of course be monitoring the COVID19 pressures intently in the coming weeks and months, and it is my intention that the 12 month countdown on necessary preparation time for health boards will not resume until pressures have subsided significantly enough to allow this work-stream to continue. For example, if by October 2020 we have returned to what could be considered more "normal circumstances", we would then target a coming-into-force date of October 2021.

This approach is of course based on the best currently available evidence and projection, and is subject to change if and when the situation evolves. Should our approach change in any way, I will of course update you immediately.

Also linked to the extension to paediatric inpatients, I am conscious that our second planned data capture around compliance with the interim paediatrics principles is due this coming May. For obvious reasons I have taken the decision to postpone this until November, pending any further developments.

Summary

- Welsh Government will proceed with the legislative steps that will allow extension of the Act's second duty within this government term as committed.
- This will be achieved through delaying the public consultation to late 2020 and the plenary debate to early 2021.
- The planned April 2021 coming-into-force date will be postponed based on at what point health boards have returned to normal enough circumstances to reasonably proceed with the necessary preparations for extension of the Act's second duty into paediatric inpatient wards.

Compliance with and reporting against the existing duties under the Act

Broadly, the duties on health boards currently under the Act are as follows:

- to calculate nurse staffing levels for adult medical and surgical wards using a prescribed triangulated methodology;
- to take all reasonable steps to maintain those calculated nurse staffing levels;
- to produce a three-yearly report to Welsh Ministers (May 2021) on the extent to which nurse staffing levels have been maintained and the impact not maintaining them has had on care.
- to have regard to providing sufficient nurses wherever nursing care is provided or commissioned;

Calculation

The wording of the statutory guidance is that health boards *should* undertake a recalculation every six months rather than *must*. There is an important legal distinction between the two. If "must" had been used, the biannual calculation schedule would be absolutely mandatory, and we would either need to consider suspending that guidance or accept that all health boards would be non-compliant with the Act. However, "should" allows for more discretion and flexibility in extraordinary circumstances. With the next biannual calculation due imminently, you will need to ask serious questions about whether the resource that goes in those calculations is better used elsewhere.

Further, there is a question around on which wards the health boards would actually be using that triangulated calculating methodology given that we expect ward purposes to change dramatically, and at a rapid pace. On the Executive Nurse Directors Skype meeting on Wednesday last week, you were united in your view that by the peak of the Covid19 pressures, it is likely that all of your currently designated adult medical and surgical wards

will have become "*Covid wards*". Those wards would technically be considered medical in nature, however given that they will be entirely novel, the lack of quality indicator information alone would make it impossible for you to perform the triangulated calculation as prescribed. There is also a fundamental question of whether the *Welsh Levels of Care* evidence-based workforce planning tool could be applied in those wards given that they will be significantly different environments to the business-as-usual medical and surgical wards where the tool was tested for 2 years.

Maintaining Nurse Staffing Levels

It is safe to say that during the additional Covid19 pressures, maintaining the nurse staffing levels that have been calculated on your adult medical and surgical wards will become an impossible challenge. Your workforces are likely to be reduced by sickness, and significant numbers of the available nursing staff will be redeployed to Covid19 response out of necessity.

However, we must bear in mind that varying from the nurse staffing level does not constitute a lack of compliance with the Act. As long as a ward remains designated as an adult medical or surgical ward, you will still be actively applying your professional judgement and taking all reasonable steps to mitigate the risk to patients on those wards. Indeed, closing those wards entirely is a reasonable step available to you if you deem it necessary. It is not a step we envisaged being commonly implemented when writing the legislation, but this public health crisis is in essence the most extreme test of the flexibility built into the Act.

Reporting

I am aware that you are due to take annual reports to your boards in May. I am also mindful that those annual reports are a voluntary step that you as a group of peers agreed to on an all-Wales basis rather than something that is mandated within the Act or its statutory guidance. In usual circumstances it is eminently sensible to provide annual assurances to your Boards that can then be aggregated to create the 3-yearly reports to Welsh Government. However in these extraordinary circumstances, you need to decide whether the time and resource necessary to produce those reports would not be more valuably redirected elsewhere.

In terms of the 3 year report (due in May 2021) which *is* a statutory requirement, the disruption caused by this pandemic will inevitably have a dramatic impact on the contents of those reports. Thanks to the work of the All Wales Adult work-stream of the Nurse Staffing Programme, we now have a consistent approach to meeting the reporting requirements of the Act. However, a key part of that approach involves enhancements to the HCMS system, which will be impacted by the additional Covid19 pressures. The timescale for delivery was initially 1 April, though I understand that has slipped by a week according to our last update. Whether the enhancements are delivered in April or not, it does not seem reasonable to ask frontline nurses to adopt a new process during what will be a national staffing emergency.

What will be important during these coming months, is that careful records are kept of the steps that you take to manage this developing situation. In April 2021, the first 3-year reports will look significantly different to how we would have envisaged at the start of this year. However, you will still be required to recount the story of what happened on your wards, for example, on what date you closed particular medical and surgical wards to repurpose them as Covid19 wards.

Overarching regard for providing sufficient nurses

Your duty under section 25A of the Act will remain an important factor in how you are deploying your nursing staff across the entirety of your health boards wherever nursing care is provided or commissioned. Even during a period where "providing sufficient nurses" will

seem like a foreign concept, your responsibility of minimising risk to patient safety through applying your professional judgement will remain.

Summary

Under these exceptional circumstances, it is the Welsh Government's position that:

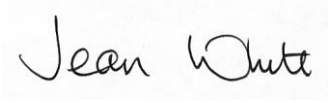
- it is within the health boards' respective discretion to proceed with or cease work on the imminently scheduled biannual re-calculation of adult medical and surgical wards;
- similarly it is within the health boards' respective discretion to indefinitely postpone the annual report to board, due May 2020;
- adult medical and surgical wards that have been repurposed as novel wards to deal with the Covid19 pandemic would be considered an exception under the definition of an adult medical ward, therefore would not be subject to the prescribed triangulated calculation methodology;
- as long as wards remain designated as adult medical and surgical wards, health boards will be expected to persist with taking all reasonable steps to maintain calculated nurse staffing levels and undertake the usual mitigating actions where possible;
- we acknowledge that those reasonable steps and mitigating actions are still likely to fall short of enabling health boards to maintain the Nurse Staffing Levels calculated during usual circumstances;
- health boards should ensure that they take whatever steps they deem necessary to record their actions taken over the coming months in order to adequately articulate within the first three-year report (due April 2021) the narrative of these extraordinary circumstances;
- health boards – through their executive nurse directors - ensure they are informed of actions being taken in other health boards, and that a consistent, collaborative approach is taken by all; and
- your professional judgement as designated persons will remain a key determinant in ensuring staffing in all areas where nursing care is either provided or commissioned is managed as appropriately as possible during an extraordinarily difficult time.

Finally, I feel I must stress the importance of remaining united as a peer group. Especially in such extraordinary times, there is clear value to a once-for-Wales approach to how health boards manage these immense pressures.

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

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

Yours sincerely,



Professor Jean White CBE
Chief Nursing Officer
Nurse Director NHS Wales

Appendix 2: List of wards which retain 25B status

Site	Name of Ward	Number of beds	Establishment during COVID-19-19		Previous funded establishment		Record the date when the purpose of the ward changed & the rationale
			RN WTE	HCSW WTE	RN WTE	HCSW WTE	
YGC	YGC COTE Ward 1	24	18.53	17.93	18.53	16.01	9/4/20 S.25B ward repurposed due to COVID 19 21/5/20 Returned to S.25B acute medical ward. Uplift in HCSW initiated in 2019 establishment review.
YGC	YGC CAU Ward 2	24	18.53	17.93	18.53	16.01	9/4/20 S.25B ward repurposed due to COVID 19 21/5/20 Returned to S.25B acute medical ward. Uplift in HCSW initiated in 2019 establishment review.
YGC	YGC COTE Ward 19	24	18.53	19.88	18.53	19.88	
YGC	YGC Gastro Ward 9	24	18.53	16.71	18.53	15.01	26/3/20 S.25B ward repurposed due to COVID 19 Uplift in HCSW initiated in 2019 establishment review.
YGC	YGC Respiratory Ward 11	23	24.33	16.71	24.33	13.64	12/3/20 S.25B Ward. Repurposed to COVID 19 respiratory ward. To include admission area for patients requiring NIV / CPAP. HCSW increased to support COVID activity. Beds reduced to 23 during COVID to provide staff well-being room.
YGC	YGC Renal / Diabetes / Endocrine Ward 12	24	18.53	17.62	18.53	15.01	14/3/20 S.25B ward repurposed due to COVID 19 Uplift in HCSW initiated in 2019 establishment review.
YGC	YGC Stroke Ward 14	28	24.33	14.09	24.33	10.91	Ward remains a S.25B adult medical ward. Uplift in HCSW initiated in 2019 establishment review.
YGC	YGC Cardiology Ward 4	24	18.53	15.01	18.53	15.01	
WXM – BCU EAST	FLEMING	23	29.43	17.40	20.69	10.02	Increase in beds from 23 to 29 funded surgical beds. Completed assessment of staffing assessment x 2 in 2019/20

Site	Name of Ward	Number of beds	Establishment during COVID-19-19		Previous funded establishment		Record the date when the purpose of the ward changed & the rationale
			RN WTE	HCSW WTE	RN WTE	HCSW WTE	
WXM – BCU EAST	PANTOMINE	29	23.74	21.13	23.74	18.25	Increase in HCA to support activity on night duty for assessment unit. Completed assessment of staffing establishment x2
WXM – BCU EAST	ENT	19	15.21	11.93	16.01	12.05	Decrease in HCA as budget covered ENT ward and ENT clinic. Completed assessment of staffing establishment x2
WXM – BCU EAST	MASON	27	18.91	14.76	18.91	13.63	Repurposed as COVID-19 ward – based on Erddig Ward template. No changes required due to acuity & dependency of patients. Increase in HCSW due to dependency needs. Agreed at establishment review.
WXM – BCU EAST	MORRIS	21	16.35	18.55	18.91	13.63	Based on 21 beds – previously funded at 27 beds.. HCSW dependency increased due to nature of patient cohort. RN reviewed at night in line with CNO for 21 pts. (Budget confirmed 11/05/2020)
WXM – BCU EAST	EVINGTON	21	15.18	12.30	15.18	12.63	Establishment based on 21 beds (Budget confirmed 11/05/2020)
WXM – BCU EAST	ACU	21	29.14	12.30	29.14	7.38	Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
WXM – BCU EAST	ERDDIG	29	24.02	16.09	24.02	12.04	Establishment reviewed for COVID-19 high care CPAP area – based on POW template currently. No adjustment needed due to acuity of patients – CPAP/NIV. Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)
WXM – BCU EAST	CUNLIFFE	25	18.91	12.30	18.91	12.30	
WXM BCU EAST	BERSHAM	27	24.02	12.30	18.91	8.71	Increase for RN acuity. Increase in HCSW due to dependency needs. Agreed at establishment review. (Budget confirmed 11/05/2020)

Site	Name of Ward	Number of beds	Establishment during COVID-19-19		Previous funded establishment		Record the date when the purpose of the ward changed & the rationale
			RN WTE	HCSW WTE	RN WTE	HCSW WTE	
YG	TRYFAN	23	17.71	8.51	17.71	8.51	Ward remains a S.25B Adult medical ward
YG	GLYDER	18	13.49	8.01	13.49	8.01	Ward remains a S.25B Adult medical ward
YG	HEBOG	28	24.96	11.42	24.96	11.42	Ward remains a S.25B Adult medical ward
YG	MOELWYN	28	22.62	8.51	22.62	8.51	Ward remains a S.25B Adult medical ward
YG	PRYSOR	12+1	12.77	8.51	12.77	8.51	Ward remains a S.25B Adult medical ward
YG	GLASLYN	26	16.82	22.62	16.82	22.62	Ward remains a S.25B Adult medical ward
YG	TEGID	28	26.89	18.82	26.89	18.82	Ward remains a S.25B Adult surgical ward

*The above information is accurate as of 20th of May 2020 and is subject to change as operational teams develop and change their operational plans.

The above required establishment have been calculated in line with the approach taken as part of the biannual calculation cycles and are based on a combination of early/late/ND and long day shift patterns and include 26.9% uplift.

List of wards previously S25B but repurposed as covid-19 wards

Site	Surgical Wards	Number of beds	Establishment during COVID-19		Previous funded establishment		Record the date when the purpose of the ward changed & the rationale
			RN WTE	HCSW WTE	RN WTE	HCSW WTE	
YGC	YGC Vascular Ward 3	18	19.81	10.54	19.81	9.2	This ward forms part of site COVID escalation plan and has the potential to be escalated to 23 beds. Ward remains a S.25B acute surgical ward.

Site	Surgical Wards	Number of beds	Establishment during COVID-19		Previous funded establishment		Record the date when the purpose of the ward changed & the rationale
			RN WTE	HCSW WTE	RN WTE	HCSW WTE	
							Uplift in HCSW initiated following establishment review in March 2020.
YGC	YGC ENT Ward 5	24	24.33	16.49	24.33	16.49	17/4/20 S.25B ward repurposed for COVID 19 combined medical and surgical. 18/5/20 returned to S.25B acute surgical ward.
YGC	YGC Trauma Ward 7	24	24.07	22.92	24.07	22.92	No change to ward purpose Ward remains a S.25B Adult surgical ward
YGC	YGC Gen Surg, Colo Rectal Ward 8	24	18.53	15.01	18.53	15.01	No change to ward purpose Ward remains a S.25B Adult surgical ward
ABH	YGC ABH Ward 6	24+	0	0	23.29	9.43	**17/3/20** Ward closed as elective orthopaedic service suspended on the YGC site as part of COVID preparation plan. All staff redeployed to YGC adult acute wards and departments.
WXM – BCU EAST	BONNEY COVID WARD						Repurposed as COVID-19 to support Women's Services Pathway. Staffing allocated accordingly from Arrivals staff but not fully funded complement for inpatient area 24/7. Supplemented from staffing from other areas
WXM – BCU EAST	PRINCE OF WALES (COVID)	21 increase from 21 to 27 beds (6 extra beds not funding but staff levels added)	15.21	11.93	16.01	12.05	Currently elective orthopaedic ward closed but staff have moved to Pantomime ward template to cover a COVID 19 ward and therefore staffing for this ward does not normally reflect the funded 21 bed for POW. Gaps in the day having to be covered from other clinical areas from medicine and surgery. Decrease in HCA and R/N as staffing reduced at weekend. COVID Ward and increase from 21 to 27 beds (6 extra beds not funding but staff levels added)
YG	DULAS	29	21.5	14.78	21.5	14.78	02/04/2020 Section 25B ward re purposed due to COVID 19
YG	OGWEN	26	16.13	21.5	16.13	21.5	06/04/2020 Section 25B ward re purposed due to COVID 19

Site	Surgical Wards	Number of beds	Establishment during COVID-19		Previous funded establishment		Record the date when the purpose of the ward changed & the rationale
			RN WTE	HCSW WTE	RN WTE	HCSW WTE	
YG	ARAN	28	26.62	14.11	26.62	14.11	02/04/2020 Section 25B ward re purposed as a COVID 19 ward
YG	ENLLI	16	Currently 2:1 staffing ratio	Currently 2:1 staffing ratio	12.54	7.3	02/04/2020 Section 25 B ward re purposed as a COVID 19 critical care area – step down – CPAP patients. Staff are deployed from critical care and other areas of the site dependant on need

Site	Ward	Additional Information / Ward areas that do not have S25B status but impacted due to COVID 19.
WXM – BCU EAST	SAU / GLYNDWR	Increase in HCA to support activity on night duty for assessment unit. Completed assessment of staffing establishment x2 in 2019/20
WXM BCU EAST	AMU ASSESSMENT	The changes were requested as a results of moving frailty to AMU and to staff AEC
WXM BCU EAST	AMU SSW	The SSW changes were to reflect the current acuity due to the change is speciality and turnover of the pts
YG	C19	On the 13th of March 2020 YG established the first COVID ward. Staff from Gogarth (AMAU) transferred to open this area in preparation for the COVID pandemic. 21 beds including an assessment area for COVID positive / suspected patients.
YG	TUDNO	Tudno is YG's day surgery unit- however this area is planned to support critical care should the COVID pandemic result in additional critical care capacity.
YG	CONWY (sau)	On the 13th of March 2020, Conwy ward re established itself as a medical and surgical assessment unit
YG	GOGARTH (amau)	On the 13th of March – staff from Gogarth transferred to C19 to open the COVID ward, in the following 2 x weeks over 300+ staff members were given training on how to manage patients during the COVID pandemic using this ward area to undertake the training (before re opening as a 2nd COVID ward)

**The above are accurate up to 20/05/2020 and is subject to change as operational teams develop and change their operational plans*

The above required establishment have been calculated in line with the approach taken as part of the biannual calculation cycles and are based on a combination of early/late/ND and long day shift patterns and include 26.9% uplift

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High level pathway in order of acuity

Home (level 0)

- Including residential and nursing care homes
- Providing palliation, community nursing input, social care

(level 1)

- Palliative care (not within last 24 hours of life)
- Oxygen
- Intravenous medication
- Medicines management
- ALL patients require Advance Care Plan including CPR status

(level 2)

- Oxygen
- Intravenous medication
- Medicines management
- Joint medical care (CoTE& Resp)
- Rehabilitation
- Access to diagnostics

(level 3)

- As Level 2 AND including
- Non-invasive ventilation
- Invasive ventilation
- Renal Replacement Therapy
- Support for Multi-organ failure

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 3.7.20
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quarter One Plan monitoring report (Q1PMR)
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Jill Newman, Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	This paper has been scrutinised and approved by the Executive Team and the Director of Performance.
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to note the report.

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

Sefyllfa / Situation:

This report provides a self-assessment by the executive leads of the progress being made in delivering the key actions contained in the 2020/21 Operational Plan for Quarter 1.

Cefndir / Background:

The operational plan has a number of key actions required to be delivered during Quarter 1 of2020/21. The Executive lead reviews on a monthly basis progress against their areas for action and RAG-rates progress. Where an action is complete this is RAG rated purple, where on course to deliver Quarter end position the rating is green. Amber and red ratings are used for actions where there are risks to manage to secure delivery or where delivery is no longer likely to be achieved. For Red rated actions a short narrative is provided.

Asesiad / Assessment

Strategy Implications

Delivery of the operational plan actions is key to implementation of the Boards strategy

Financial Implications

Delivery of the operational plan within the budget set by the Health Board is part of ensuring resources are well-managed and care effectively provided within the allocated resources.

Risk Analysis

The RAG-rating reflects the risk to delivery of key actions

Impact Assessment

The operational plan has been Equality Impact Assessed.

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Cyfarwyddiaeth Cynllunio & Perfformiad
Planning & Performance Directorate

BCU Quarter One Plan Monitoring Report

May 2020

Overview and Purpose of this Report

- The Quarter 1 Plan of the Health Board has been agreed in Cabinet and submitted to Welsh Government
- The Plan is produced under Command and Control in relation to the Covid-19 Pandemic and recognises that the disruptive nature of the pandemic has shortened planning horizons, resulting in plans being time limited to quarterly plans for 2020-21
- The Quarter 1 plan relates to the mobilisation phase of Covid-19 response, need to maintain essential non Covid-19 services to minimise risk of harm for life-saving or life-impacting treatments.
- This report is a self-assessment by the SROs for each of the work streams of likelihood to deliver the actions set out in the plan by the 30.6.20. with supporting narrative where the risk to delivery is red rated i.e. highly unlikely to be achieved. This report provides an update from each SRO for the end of May 2020 actual position.
- Work is underway in developing the Q2 plan which will also reflect the shift in phasing of response to the pandemic from mobilisation towards parallel running of the pandemic and re-activation of some business as usual activities where it is safe to do so. This will reflect transition to sustainable service delivery phase of the plan. In the Q2 plan actions incomplete at the end of Q4 2019/20 will be included with revised timescales to deliver, where these actions are still relevant for delivery in 2020/21.

RAG	Every month end	By end of Quarter	Actions depending on RAG rating given
Red	Off track, serious risk of, or will not be achieved	Not achieved	Where RAG given is Red: - Please provide some short bullet points expaining why and what is being done to get back on track
Amber	Some risks being managed	N/A	Where RAG is Amber: No additional Information required
Green	On track, no real concerns	Achieved	Where RAG is Green: No additional Information required
Purple	Achieved	N/A	Where RAG is Purple: No additional Information required

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Chapter 1 Planning Work-stream Key Actions: 18th May to 30th June 2020

Ref	Lead: SRO Planning Workstream *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP1.1	Continue to monitor current and future COVID-19 demand, its impact on capacity and the implications for other services;	G	G
QOP1.2	Consider the options for deploying surge capacity and make recommendations as to scope and timing of deployment;	G	G
QOP1.3	Monitor the impact of changes within our services upon key performance measures e.g. screening programmes, cancer standards, access to primary and secondary care etc. and review service delivery recommendations accordingly;	G	G
QOP1.4	Monitor the quality and safety impacts of services and associated risks, and recommend changes to Executives as required;	A	A
QOP1.5	Maintain a dynamic organisational service delivery, activity and performance plan for the Health Board;	A	A
QOP1.6	Capture and collate pathway changes and new ways of working to ensure these are optimised – Deputy Chief Executive	G	G

Chapter 2 Covid-19 Response Key Actions: 18th May to 30th June 2020

Ref	Lead: COVID 19 Gold Commander *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP2.1	Continue to revisit planning assumptions on a regular basis as further information and analysis becomes available. Version 2.5 of the model, which is more optimistic, is currently being evaluated.	A	G
QOP2.2	Undertake further specific work on demand and provision of patient ventilation, where demand across Wales appears to be much lower than the current models predict, and on projecting demand on a health community basis.	G	G
QOP2.3	Prioritise analytical support to include health and care to guide short term decision making. Work with local partners and other Health Boards to share modelling approaches to inform demand for health and care.	A	A

Chapter 3 Covid-19 Test, Track & Protect (TTP) Key Actions: 18th May to 30th June 2020

Ref	SRO: Director of Public Health *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP3.1	Scale up testing. Implement testing requirements from Welsh Government as these develop e.g. care home staff and residents	G	G
QOP3.2	Establish a dedicated work stream to urgently support and deliver locally the national Public Health Protection Response Plan e.g. Preventing the spread of disease: Test, Trace and Protect (A large non-specialist workforce will be required to deliver.)	A	G
QOP3.3	North Wales testing laboratory facility operational	G	G

Chapter 4 Primary and Community Care Operational Delivery Key Actions: 18th May to 30th June 2020 *(Page 1 of 2)*

Ref	Lead: SRO Operations Primary Care, Community and Public Health *(unless indicated otherwise)*	RAG rating –likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP4.1	Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.	G	G
QOP4.2	Review the role and number the Local Assessment Centres (LACs) as part of a longer term plan to care for COVID patients.	G	G
QOP4.3	Work with partners to stratify and proactively contact high-risk patients with ongoing care needs; proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to COVID19, with a focus on Chronic Conditions Management , new pathways and managing demand changes for non COVID patients.	G	G
QOP4.4	Review of OOH staffing risks and mitigation and development of future OOH plans, working more closely with in hours provision	A	A
QOP4.5	Continue to deliver a community based stroke rehabilitation services whilst planning for the reintroduction of sustainable stroke services	R	A
QOP4.6	Increase acute paediatric OPD activity remotely and with reintroducing face to face appointments particularly for new referrals, Reach agreement with tertiary care re outreach specialist clinics and restarting Increase advice and support for professionals (GPs)	A	G
QOP4.7	All key areas of Eye Care are being reviewed to include cataract stratification, glaucoma refinement and ongoing care. The review also considers diabetic and other medical retina conditions such as age related macula degeneration (WMD).	A	A

Chapter 4 Primary and Community Care Operational Delivery Key Actions: 18th May to 30th June 2020 *(Page 2 of 2)*

Ref	Lead: SRO Operations Primary Care, Community and Public Health *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP4.8	Further improve access to End of Life Medication to ensure these critical medicines are accessible across North Wales	G	G
QOP4.9	Work with secondary care colleagues to implement the 'Consultant Connect' specialist advice service; ensure cancer, urgent and routine referrals to secondary care as normal, using 'advice and guidance' options where appropriate.	G	G
QOP4.10	Support care homes, including the implementation of the revised discharge policy and with a review of current service provision, sharing of good practice e.g. virtual ward rounds	A	G
QOP4.11	Provide local support to NHS communications campaigns encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.	G	G
QOP4.12	Further develop escalation reporting for Community Pharmacies	G	A
QOP4.13	Feed into medical staff planning for field & community hospitals, ensuring that medical workforce plans are aligned to agreed GP roles in hospitals, Local Assessment Centres, out of hours services and general practice demand	A	A
QOP4.14	All approved plans to establish community hospital additional surge bed space will be complete in order that the Hospitals are responsive to changes in volumes of COVID patients and flexible to increasing non-COVID activity as capacity allows.	G	G

Chapter 5 Operational Acute Care Delivery Key Actions: 18th May to 30th June 2020

Ref	Lead: SRO Operations Acute *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP5.1	Ensure our consent process informs patients of risk during their admission (East are piloting this using revised documentation) Any patient showing signs and symptoms for COVID would be not be offered surgery	G	G
QOP5.2	Development of pathways for urgent pre-operative assessment and diagnostics which are at the early stages of development.	G	G

Chapter 6 Covid-19 Surge Plan Key Actions: 18th May to 30th June 2020

Ref	Lead: SRO Operations Acute & SRO Operations Primary Care, Community and Public Health *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP6.1	Develop early warning/trigger systems E.g. R value, 111, primary care, WAST, local authorities	G	A
QOP6.2	West, Centre and East will develop plans to demonstrate how a split COVID hospital could work operationally	A	A
QOP6.3	Complete assessment of Llandudno infrastructure to support elective surgery.	A	G
QOP6.4	Abergele site plan prepared. We will make a decision on use of Llandudno and Abergele as these site could be considered for both COVID and non-COVID demand. This would require decisions being made about current patients on the Llandudno site and Colwyn Bay to accommodate existing patients.	A	R
QOP6.5	In the absence of face-to-face visits, work together to stratify and proactively contact high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.	A	A
QOP6.6	We will explore cold sites or external providers to support with planned care activity. A pilot has commenced at Wrexham Maelor for additional theatre capacity to test the model from 27/04/2020	A	G
QOP6.7	We will consider development of a single site “Hub and Spoke” model for surgery	A	G
QOP6.8	Triggers to be determined for opening any additional capacity in line with demand to be approved through command structure (on receipt of new modelling)	A	A
QOP6.9	Spire contract will cease 5th July 2020 with action required to provide notice by 5th June 2020 regarding any future plans or requirements)	G	G

QOP6.4: The Abergele site plan is being considered within the overall option appraisal for Planned Care. This work is not yet complete, however is progressing through the Planned Care Improvement Group and will form part of our Q2 delivery plan

Chapter 7 Workforce Plan Key Actions: 18th May to 30th June 2020

Ref	Lead: SRO Workforce *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP7.1	Ensure working conditions are safe for our staff including provision of PPE equipment and ensuring appropriate rest and working patterns for staff	A	A
QOP7.2	Continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area.	A	A
QOP7.3	Ensure that appropriate testing systems for staff are in place as determined by the Testing Strategy	A	A
QOP7.4	Implement Black, Asian and minority ethnic (BAME) guidance	A	A
QOP7.5	Ensure that workforce planning is integral to our revised clinical pathways and plans to re-introduce essential and routine services.	A	A
QOP7.6	Co-ordinate appropriate re-deployment and training and utilising key transferable skills	G	G
QOP7.7	Provide on-going recruitment to our substantive structures	G	G
QOP7.8	Co-ordinate of support from our volunteer workforce	G	G
QOP7.9	Provide wellbeing and psychological support	G	G
QOP7.10	Monitor sickness levels and reasons	G	G

Chapter 8 Maintaining Essential Services Key Actions: 18th May to 30th June 2020

Ref	Lead: Director of Nursing and Midwifery *(unless indicated otherwise)*	RAG rating – likelihood of delivery by 30.6.20	Actual Position at the End of May 2020
QOP8.1	Review harm, prioritise and risk stratify waiting lists.	A	A
QOP8.2	Specialty plans developed in line with essential services framework and other key guidelines	A	A
QOP8.3	Continue to implement alternative pathways including use of e- consultation and patient initiated outpatient follow up (e.g. resulted in 30% reduction in Orthopaedic outpatient demand)	G	G
QOP8.4	Maintain provision of essential services where it is safe to do so, delivered through our re-defined care pathways and making use of all available capacity within NHS and independent hospitals.	G	G

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.pbc.cymru.nhs.uk
  www.bcu.wales.nhs.uk
- Stats Wales www.statswales.wales.gov.uk

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 Committee 3.7.20
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Quality & Performance (QAP) Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Mark Wilkinson Executive Director of Planning & Performance
Awdur yr Adroddiad **Report Author:**	Jill Newman, Director of Performance
Craffu blaenorol: **Prior Scrutiny:**	This paper has been scrutinised and approved by the Director of Performance.
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

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

Sefyllfa / Situation:

It is important to note that performance reporting of many of the national indicators has been stood down to enable the health board to focus on the mobilisation phase of the pandemic. Staff time has been released to manage the pandemic and therefore the data included in this report has not been subject to the full level of validation and quality control as would normally be included in performance reports.

This report includes available indicators from the National Delivery Framework, together with a section on Covid-19 and Essential Services Delivery.
The operational plan has moved to a quarterly planning cycle. Progress of actions in the Q1 plan are being monitored by the Q1 Plan monitoring report which should be read alongside this report. For Q2 planning cycle the actions and associated national measures are being cross-referenced to support integration.
Many of the measures scrutinised by this committee are not reported monthly and therefore for completeness and appendix is provided in the report which documents all measures reportable to the committee and the frequency of the information being available.

Cefndir / Background:

Our report outlines the key performance and quality issues that are delegated to the Quality, Safety & Experience Committee. The summary of the report is now included within the Executive Summary pages of the QAP and demonstrates the work related to Covid-19, essential service delivery as well as the key measures contained within the 2020-21 National Delivery Framework. This framework has been revised to provide performance measures under the Quadruple Aims set out in A Healthier Wales.

Asesiad / Assessment

Strategy Implications

The performance measures within the QAP are aligned with the Annual Delivery Framework for NHS Wales.

Financial Implications

The financial benefits arising from high quality safe care are recognised and the cost of poor performance both to the individual patient, staff morale, organisational reputation and financial cost is integral to improving the performance of the Health Board

Risk Analysis

The report highlights the increased risk to population health arising directly and indirectly from Covid-19 . Additional information in relation to Essential Services is included in the Essential Service report which is on the QSE agenda this month.

Recommendation

The Quality, Safety and Experience Committee is asked to scrutinise the report and to consider whether any area needs further escalation to be considered by the Board.

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Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Quality and Performance Report







Quality, Safety & Experience Committee

May 2020

About this Report

Covid-19 Pandemic

It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in April and May 2020 is not compared as 'like-for-like' to previous months/ years performance. It is also important to note that national reporting and performance management arrangements have been suspended at this time. In order to release staff time to manage the mobilisation of the pandemic response normal validation and sign off processes have been reduced, so caution needs to be applied to data quality presented in the report.

This report is the first presentation of the proposed Quality and Performance (QAP) Report, replacing the Integrated Quality and Performance Report(IQPR) used in 2019-20.

The content of this month's report has been heavily impacted by the Covid-19 Pandemic.. The information provided in this report is produced while the Health Board is under Command and Control Major Incident operations. The fully developed report originally intended for the Quality, Safety and Experience Committee will be present when reporting is re-established.

The format of the report reflects the published National Delivery Framework for 2020-21. This aligns to the Quadruple aims contained within the statutory framework of A Healthier Wales.

Additional sections are added to reflect Covid-19 key performance indicators and the work on maintaining essential services.

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

The operational planning for 2020-21 has been impacted by the pandemic with planning cycles re-defined into quarterly plans. The Quarter 1 operational plan was submitted to Welsh Government on 18th May. The likelihood of delivery of the actions contained within this plan are reported in the accompanying Q1 Operational Plan monitoring report..

As a consequence of the changes in the planning cycle for 2020-21 and the uncertainty around the future levels of Covid-19 the ability to produce month on month profiles to monitor performance against is severely limited. Therefore the report contains factual information on performance indicators without consideration of the delivered performance against plan or a forward trajectory of future performance.

The direction of travel of performance is indicated through trend arrows (*shown below*)

↑ Performance has improved since last reported

↓ Performance as got worse since last reported

→ Performance remains the same as last reported

For May 2020, the performance has not been RAG (Red, Amber, Green) rated as national performance management arrangements have been stood down. The information provided is management information only.

The intention for future reports is to continue to align the reporting of covid-19 related pandemic indicators with the essential services service status and the National Delivery Framework while developing the reporting against the actions in the quarterly operational plans. As patient and staff safety permit, we will recommence the development of profiles for delivery for activity taking place in short-term cycles, reporting on referrals, new ways of working, emergency and elective activity and waiting lists.

Headlines

Deterioration in CAMHS performance

Decrease in referrals , recovering in Cancer Services

Rate of infections lower than same period last year

Key Messages

Covid-19 continues to circulate and bed occupancy is starting to increase

The impact of Covid-19 may lead to lack of confidence for patients to present to services

Essential services largely maintained, however activity significantly reduced

Executive Summary

The committee are asked to note the following:

Covid-19 . The Health Board staff and partners have worked tirelessly to manage the first wave of Covid-19.Sadly we have seen deaths resulting from the virus and this has impacted on our overall mortality rates. Covid-19 is continuing to circulate and this has impacts beyond those patients directly affected by the virus. Initially attendances to ED dropped dramatically , along with presentations to Primary Care and referrals into secondary care. These are now recovering, however concern exists that some patients with worrying symptoms or serious conditions will present late. This may result in a peak of demand in the Autumn at a time when we are preparing for both Covid-19 continuing and Winter pressures.

The impact of Covid-19 on normal services has been such that routine services have been postponed or severely curtailed to ensure staff and resources could be released to manage the pandemic but also to protect staff and patients from nosocomial transmission of the virus and minimise footfall on hospital premises. A number of patients are shielding or self-isolating due to pre-existing medical conditions making access to service more difficult. Increased use of technology has supported digital communications for patients and this will extend further in quarter 2.

Throughout the pandemic the clinical teams have innovated to support patients, increasing the use of digital technology and re-designing at pace clinical pathways to address the needs of patients based on risk- stratification. The learning from this will be important going forward and therefore a survey is underway to capture this learning.

Test Tract and Protect is being put in place and the teams are addressing outbreaks in the virus.

Essential Services. The Health Board has strived to maintain essential services , completing 3 reviews of service status internally and one for commissioned services over the past two months. A more detailed report on these services is an agenda item for this Committee. It is noted that Essential Services are likely to come under increasing pressure in future moves as the scope and volume of patients under this framework expands.

Quadruple Aim 1: Prevention. Screening services suspended during the pandemic are now re-starting and plans are developing to catch up on childhood vaccinations delayed during school closures. It is noted that the end of year cover report shows good take up of childhood immunisations at a BCU level.

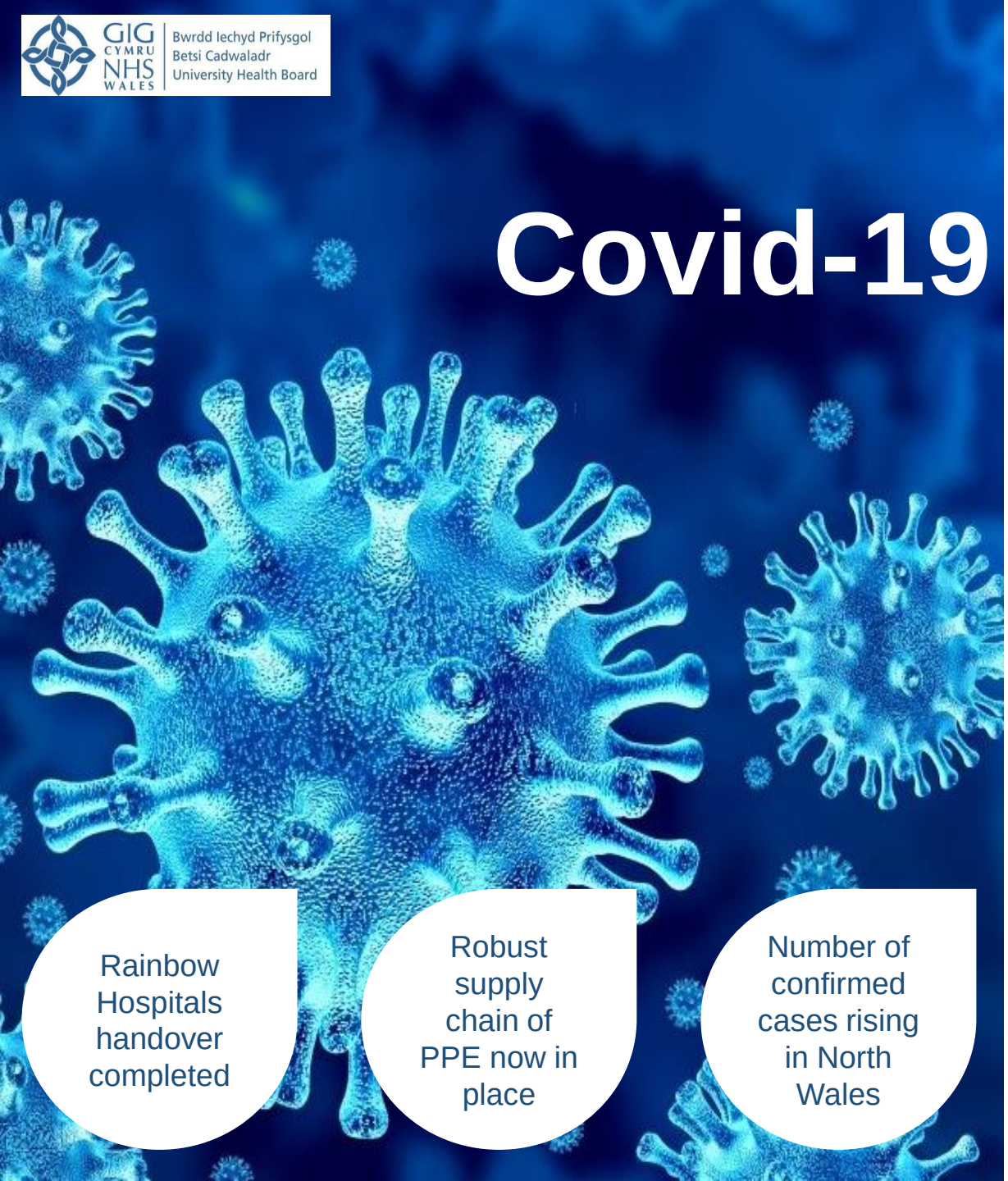
Quadruple Aim 2: Digitally accessible health care. Primary Care has become fully digitally enabled for consultations during the pandemic , Consultant Connect has been implemented to provide advice and guidance between primary and secondary care. Virtual consultations have increased in secondary care and AttendAnywhere video consultations is reaching the end of the testing phase. Patient experience of this is being captured to inform the roll out programme.

Infection prevention data is included within the report which demonstrates on-going progress in the management of health care acquired infections.

Quadruple Aim 3: Staff motivated and sustained. There have been areas of service were unavoidable staff absences due to covid-19, staff shielding or staff self-isolation have proved challenging. This is reflected in increased sickness absence rates. Staff have responded excellently , with considerable flexibility to rapidly be redeployed, develop new skills or lead development of revised clinical pathways. Increased psychological support has been welcomed.

Quadruple Aim 4: Improved working with Local Authorities has supported the development of a community dashboard. This includes care home information.

The fractured neck of femur collaborative has reported against KPIs established for improvement and compliance.



Key Messages

- Number of Confirmed cases rising in North Wales
- Testing for Covid-19 is continually being increased
- Modelling suggests the Covid-19 incidence will continue for some time

Measures

Measure	at 25th June 2020
Total number of tests for Covid-19	**30,538**
Number of results: Positive/suspected	**3,515**
Number of results: Negative	**27,023**
% Prevelance of Positive Tests	**11.5%**
Number of Deaths - Confirmed Covid-19	**350**

Source: Public Health Wales coronavirus Dashboard, accessed 26th June 2020

Essential Services

Key clinical pathways reviewed and Implemented

Definitions of “Essential Services” Published

Developing plans for future provision of Planned Care

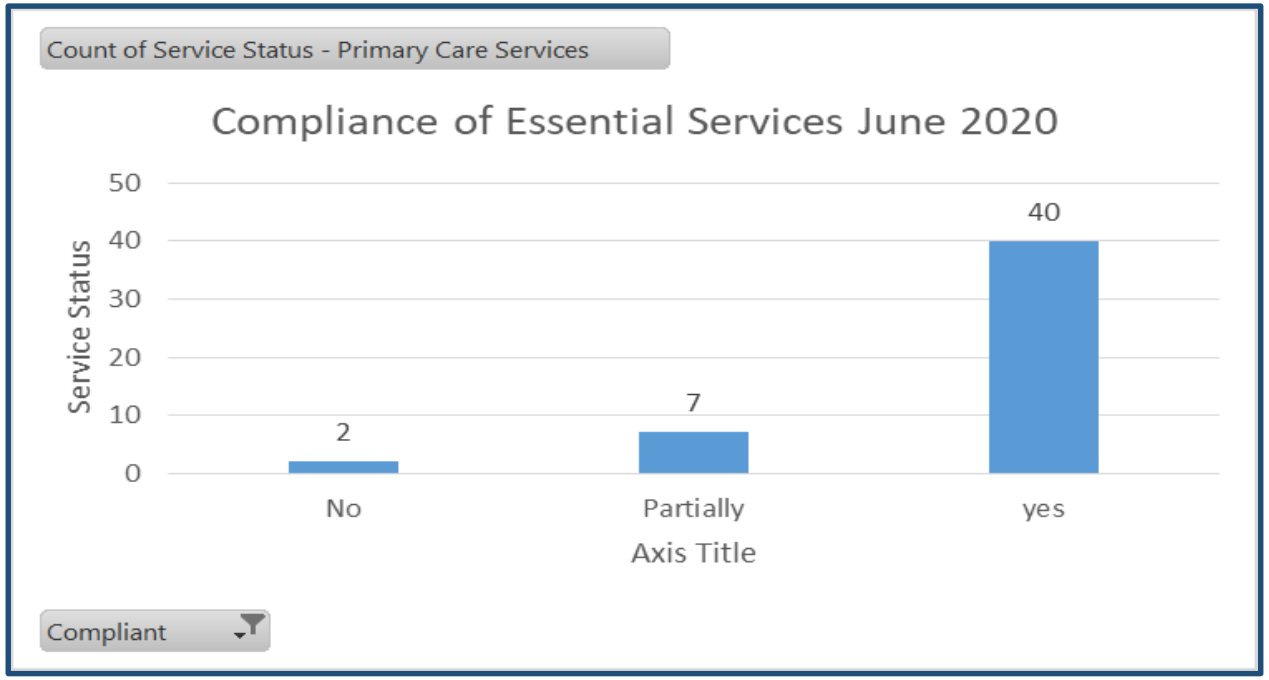
Key Messages

Essential Services are those elements of service required to mitigate harm of life-threatening or life-changing conditions that must be maintained throughout Covid-19

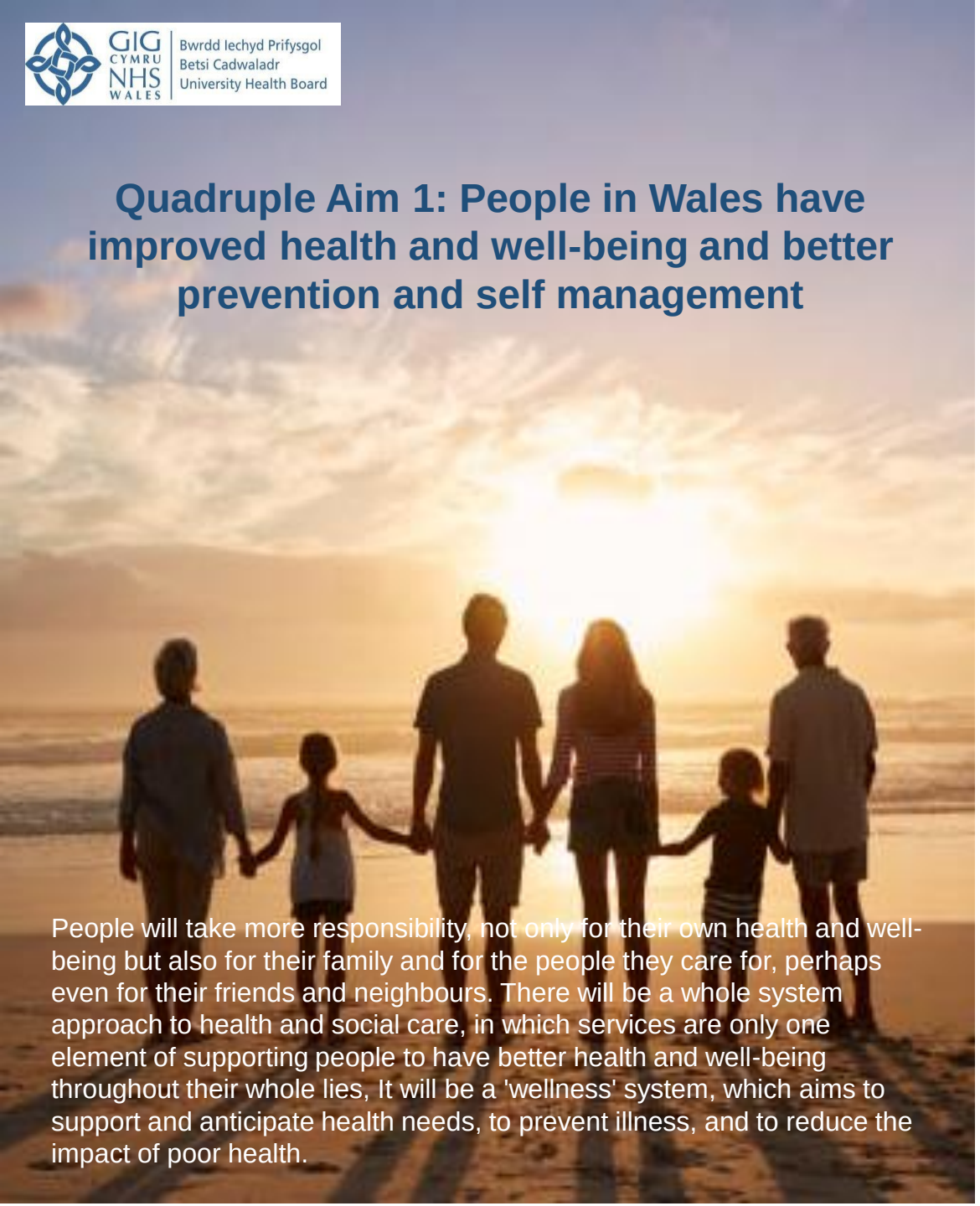
3 internal and 1 commissioned service reviews completed

Increasing pressure expected on these services in future months

Measures



Quadruple Aim 1: People in Wales have improved health and well-being and better prevention and self management



People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole lies, It will be a 'wellness' system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

Key Messages

- Screening services suspended under Covid-19 are to restart from July 2020
- Cover report for Childhood vaccinations at March 2020 should good levels of take-up of programmes
- Extended crisis support provided for families and young people during lock-down

Measures

Frequency	Measure	Target	Actual	Trend
Quarterly	3 doses of the hexavalent '6 in 1' vaccine by age 1	**>= 95%**	96.70%	↑
Quarterly	2 doses of the MMR vaccine by age 5	**>= 95%**	94.80%	↑
Monthly	Care and treatment plan (aged under 18 years)	**90%**	90.40%	↑
Monthly	Care and treatment plan (aged 18 years and over)	**90%**	89.02%	↓

Although we did not achieve the 95% target rate for 2 doses of MMR by age 5, we are the best performing Health Board in Wales in terms of this measure.

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.

- **Consultant Connect advice service implemented**
- **Mental Health Access being re-established**
- **Emergency Optometry and Dental Hubs established**

Key Messages

- Primary Care digital access and virtual consultations established
- Delayed Transfers of care significantly reduced
- New discharge pathways implemented and monitored as to impact on future bed capacity

Top 4 Measures (based on movement up or down)

Frequency	Measure	Target	Actual	Trend
Monthly	Percentage of mental health (Adult) assessments undertaken within 28 days	**>= 80%**	84.91%	↑
Monthly	Percentage of therapeutic interventions (Adult) within 28 days	**>= 80%**	85.11%	↑
Monthly	Percentage of complaints that have received a final reply	**75%**	72.00%	↑
Monthly	Total Number of health board delayed transfer of care	**Reduction**	35	↑

Quadruple Aim 2: Measures

Frequency	Measure	Target	Actual	Trend
Monthly	Cumulative rate of E-Coli cases per 100,000 population	TBC	52.26	↑
Monthly	Cumulative number of E-Coli cases	TBC	61	↑
Monthly	Cumulative rate of S.Aureus cases per 100,000 population	TBC	16.28	↑
Monthly	Cumulative number of S.Aureus cases	TBC	19	↑
Monthly	Cumulative rate of MRSA cases per 100,000 population	TBC	1.71	↑
Monthly	Cumulative numberof MRSA cases	TBC	2	↑
Monthly	Cumulative number of MSSA cases	TBC	17	↑
Monthly	Cumulative number of Klebsiela cases	TBC	15	↑
Monthly	Cumulative number of Aeruginsoa cases	TBC	8	↑

Frequency	Measure	Target	Actual	Trend
Monthly	Percentage of mental health (Adult) assessments undertaken within 28 days	>= 80%	84.91%	↑
Monthly	Percentage of therapeutic interventions (Adult) within 28 days	>= 80%	85.11%	↑
Monthly	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	26.49%	↓
Monthly	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	>= 80%	30.95%	↑
Monthly	Total Number of health board delayed transfer of care	Reduction	20	↑
Monthly	Total Number of health board delayed transfer of care bed days	Reduction	1,046	↑

Quadruple Aim 2: Narrative – Infection Prevention

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

At this stage the Welsh Government have not set an Improvement Goal for Health Care Acquired Infections (HCAIs) this financial year, however HBs and Trusts, "are encouraged to continue to strive to reduce healthcare associated infections in line with the overall requirements of the UK 5 year AMR strategy and action plan". For BCU this will be a continuation of the trajectories for 2019/20 taking into consideration the 12% reduction applied to Clostridium Difficile Infection (CDI) for 2019/20.

The numbers of infections in terms of rates/1,000 admissions to date have increased across Wales. This is likely in most cases to be due to a reduction in elective admissions in recent months, but we are monitoring these numbers closely and will continue to respond and report to any potential clusters and or significant increases and trends.

It is not unusual to see variation in numbers month on month. This is expected. CDI infections are slightly higher than the same period last year but have decreased since last month, April.

MRSA infections are inaccurate due to a lab error whereby an MSSA Blood Stream Infection (BSI) infection, was recorded as an MRSA BSI. A datix has been completed and we have been assured this will be removed for next months reporting from Public Health Wales (PHW). The other MRSA infection was unavoidable as a Healthcare Associated Infection (HCAI) as it was due to an injecting drug user in the community.

Compared to the same period last year MSSA infections and all the other gram negative infections are lower than the same period last year apart from Pseudomonas, 8 infections to end of May, 50% were community onset and had positive blood cultures on admission.

Quadruple Aim 2: Narrative – Mental Health and DToC

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

CAMHS
In March all families were contacted, needs and risks reviewed and prioritised. Support was paused if the contact/intervention could wait three months. For families needing ongoing support this was provided remotely using telephone and Skype and those young people assessed as high risk continued having face to face support, with PPE in place.

Routine activity stopped and resources were moved into extending the hours of crisis provision up until 22:00, to support young people admitted to the paediatric wards with self-harming or suicidal presentations.

Early Intervention work in the school setting stopped, discussions now underway with Education to plan how to provide support as schools re-open.
Capacity to meet the MHM target in April was significantly impacted. In May this was an improved position, however outcome data inputting was problematic due to remote working and is being addressed and updated. Referrals are down by 61%

Adult Mental Health
The Leadership in Mental Health has been strengthened with the Medical Director becoming the Executive Lead for the Service.

Patients inadvertently discharged at the start of the pandemic have been contacted to assess their needs and return to service as appropriate. Investigation is progressing to understand the learning from this incident.

Weekly reporting of service status is showing all services are operational.

Delayed Transfers of Care (DToC)
Delayed transfers of care are not currently reported, however BCU have maintained the delayed transfers of care data base demonstrating significant reduction in delayed transfers of care
.
New discharge pathways and suspension of previous continuing health care arrangements have contributed to this improvement.

Medically fit to discharge and daily discharges for these patients are now reported. The 5 new discharge pathways are reported as snapshots twice weekly.

As policy changes have been applied to protect the care home sector the number of patients requiring testing and self-isolation prior to transfer to a care home is increasing. With the impact of 28 days post positive test for admissions to care homes being implemented the risk to the care home sector and to hospital bed capacity is being kept under review, with consideration being taken of the requirements for surge capacity.

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.

Rate of Final Replies to complaints improved and almost on target

New clinically developed pathways in place.

Staff absence rates impacted by Covid-19

Key Messages

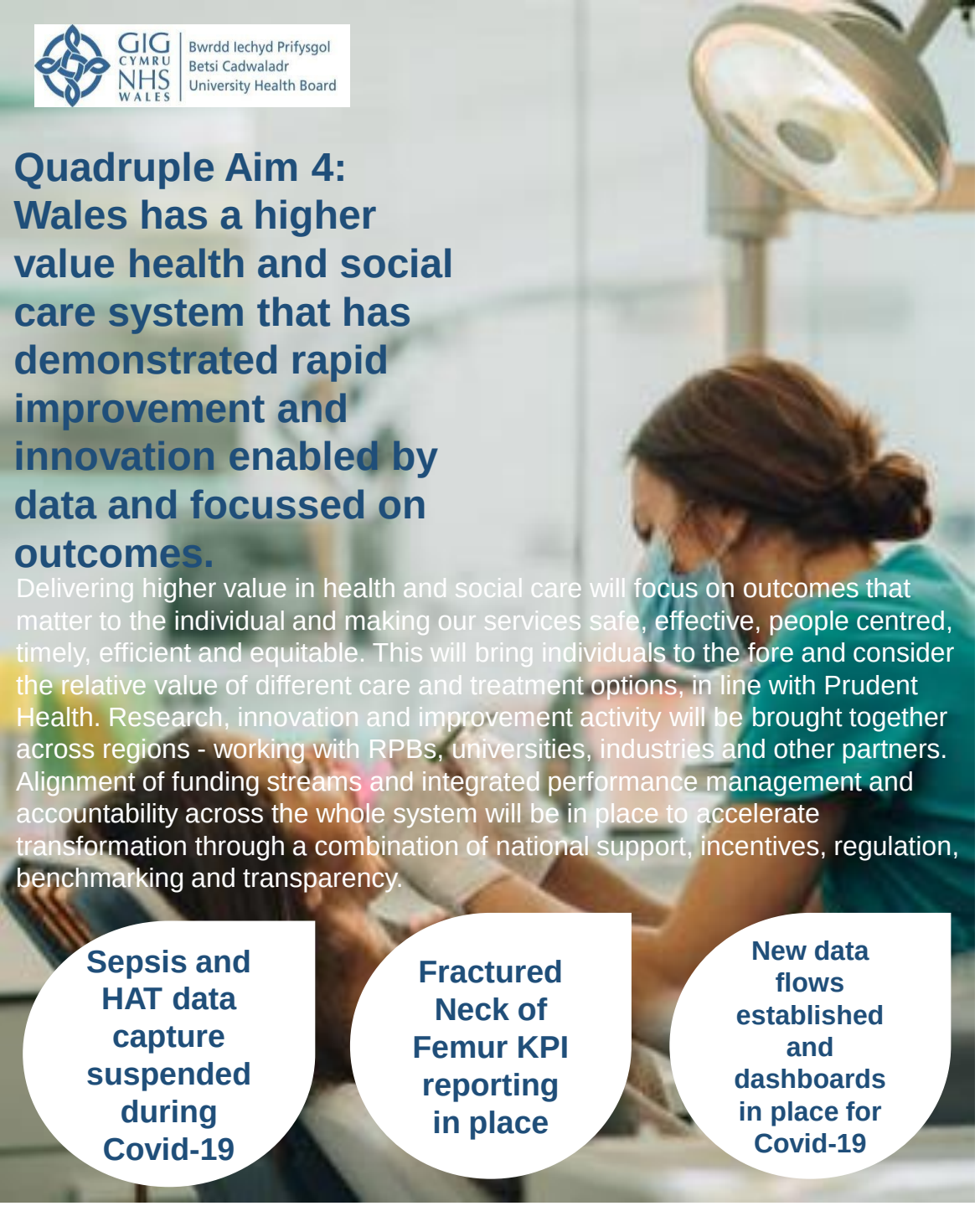
- Increased clinical engagement and clinical leadership demonstrated
- Additional psychological support provided for Staff
- Excellent joint working with Staff representatives

Measures

Frequency	Measure	Target	Actual	Trend
Monthly	Percentage of complaints that have received a final reply	75%	72.00%	↑
Monthly	Number New Never Events	0	1	↓

There has been a continued focus on ensuring timely completion of complaint responses during the COVID-19 pandemic and the corporate team has supported and deployed staff into local teams in order to maintain the progress that has been made. The corporate team has also implemented a new virtual contact centre for complaints to improve experience and process. The review of the complaint process was put on hold, and has been re-started in June 2020.

One Never Event occurred in the month. This is subject to a serious incident investigation and is detailed within the SI Report to the QSE Committee.



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.

Delivering higher value in health and social care will focus on outcomes that matter to the individual and making our services safe, effective, people centred, timely, efficient and equitable. This will bring individuals to the fore and consider the relative value of different care and treatment options, in line with Prudent Health. Research, innovation and improvement activity will be brought together across regions - working with RPBs, universities, industries and other partners. Alignment of funding streams and integrated performance management and accountability across the whole system will be in place to accelerate transformation through a combination of national support, incentives, regulation, benchmarking and transparency.

Sepsis and HAT data capture suspended during Covid-19

Fractured Neck of Femur KPI reporting in place

New data flows established and dashboards in place for Covid-19

Key Messages

- Continued increase in Mortality Rate, up from 0.74% to 0.85% in 12 months
- Increased system working to link Health and Social Care Data
- Fracture Neck of Femur collaborative developed

National Hip Fracture Database - Best Practice Measures

Overview of Wales	BCU			Benchmarks				
	YG	YGC	WMH	NHFD	Wales	England	Northen Ireland	Expectation
Prompt Orthogeriatric review %	**46%**	**47%**	**69%**	89%	61%	91%	82%	**75%**
Prompt Surgery %	**75%**	**61%**	**69%**	68%	65%	69%	20%	**75%**
NICE Compliant Surgery %	**68%**	**65%**	**74%**	72%	71%	72%	74%	**75%**
Prompt Mobilisation %	**82%**	**79%**	**87%**	80%	73%	81%	83%	**75%**
Not delirious post-op %	**27%**	**43%**	**40%**	66%	51%	67%	35%	**75%**
Return to original residence %	**71%**	**73%**	**75%**	69%	70%	69%	75%	**75%**

Source: National Hip Fracture Database, accessed 25th June 2020

Quadruple Aim 4: Measures

Frequency	Measure	Target	Actual	Trend
Monthly	Crude hospital mortality rate (74 years of age or less)	**Reduction**	0.85%	↓
Monthly	Percentage of deaths scrutinised by an independent medical examiner	**Improve**	***Not available**	
Monthly	In-patients 'Sepsis Six' within one hour of positive screening	**Improve**	100%	→
Monthly	Emergency Department 'Sepsis Six' within one hour of positive screening	**Improve**	55.50%	↑
Monthly	Patients meeting NICE head injury guidelines that receive a CT scan within 60 minutes	**TBC**	***Not available**	
Monthly	Hip fracture that received an orthogeriatrician assessment within 72 hours age 60 and over	**>= 75%**	54.00%	**New**
Monthly	Episodes clinically coded within one reporting month	**>= 95%**	92.60%	↑

Quadruple Aim 4: Narrative

Covid-19 Pandemic
It should be noted that all services have been impacted by the Covid-19 Pandemic, and/or the measures put in place to combat the spread of Covid-19. Although it is important that we continue to monitor and manage performance, it is recommended that the performance reported in May 2020 is not compared as 'like-for-like' to previous months/ years performance.

Mortality

During the Covid 19 pandemic, the stage 1 mortality screening reviews have continued on all sites (92% compliance overall) although the stage 2 reviews were stood down.

At the current time there is no Medical Examiner in post although active recruitment has started and candidates will be interviewed in July 2020 with a view to taking up posts in September 2020.

Timely Interventions

Sepsis

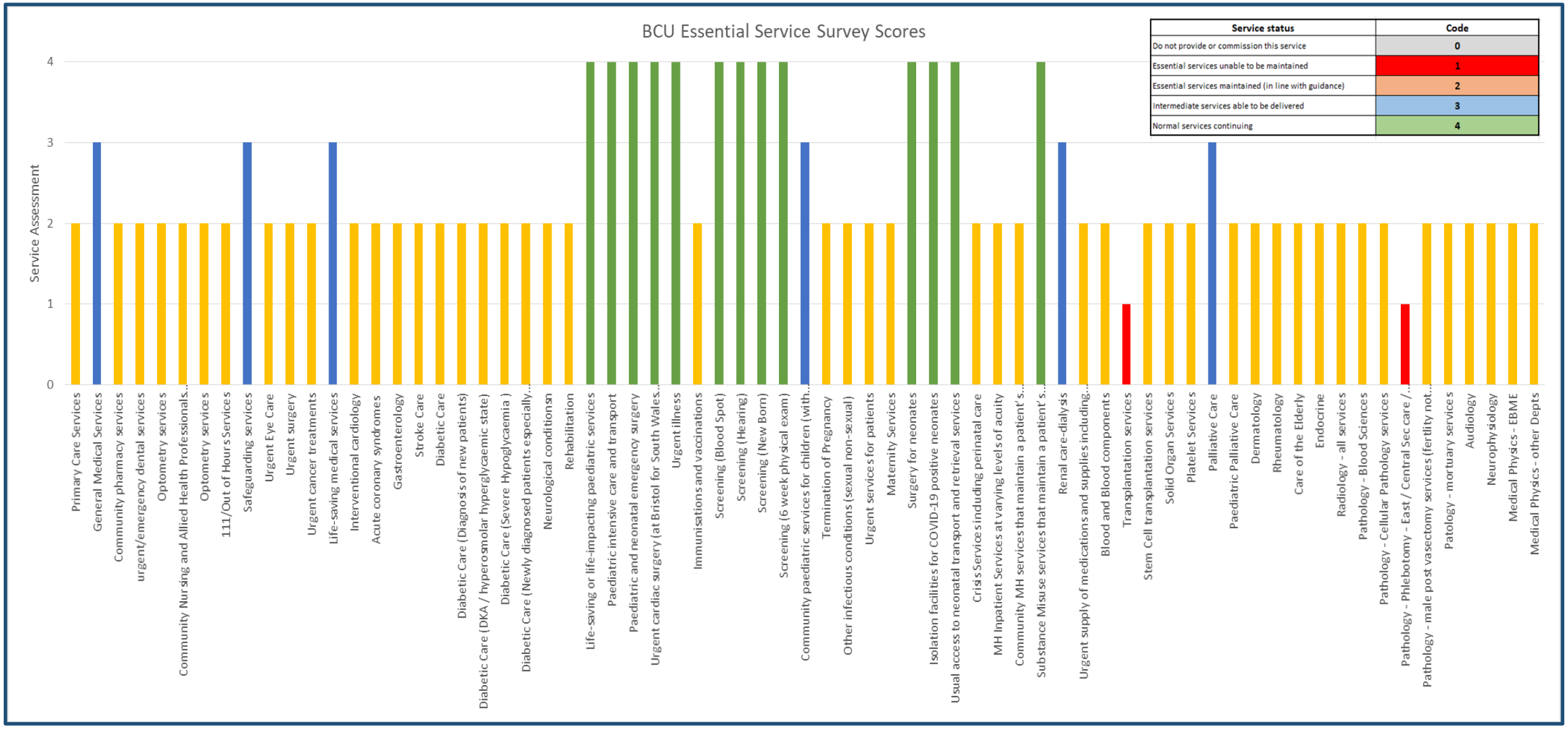
During the Covid-19 pandemic, the sepsis improvement meetings and data collection was stood down. Therefore the data are unreliable with 10 or less completed forms across the Health Board from April 2020. Work is in progress to re-establish the weekly improvement meetings and so improve data capture. (NB this is from the Sepsis Dashboard in IRIS). Once these are re-established we will consider a further virtual collaborative event. The crude mortality for non-elective septicaemia remains below the peer group (to April 2020; Source CHKS).

Hip Fracture Orthogeriatrician Review

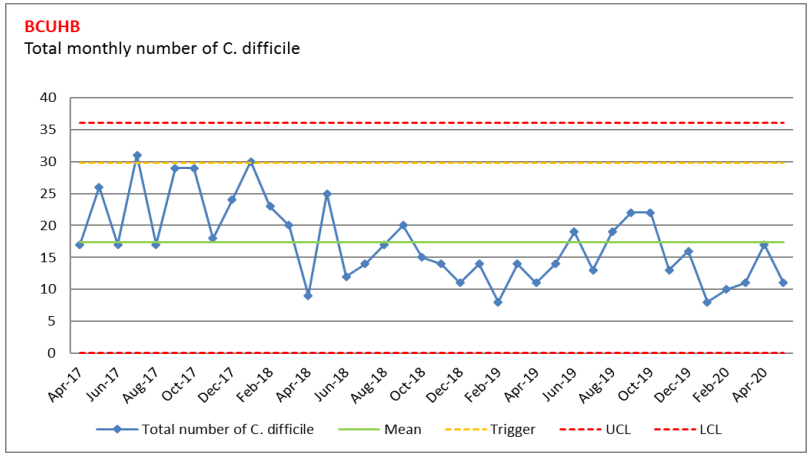
A new measure in the NHS Wales Delivery Framework for 2020/21, this measure is one of 6 reported via the UK-wide National Hip Fracture Database (NHFD). The latest available figures are for April 2020.

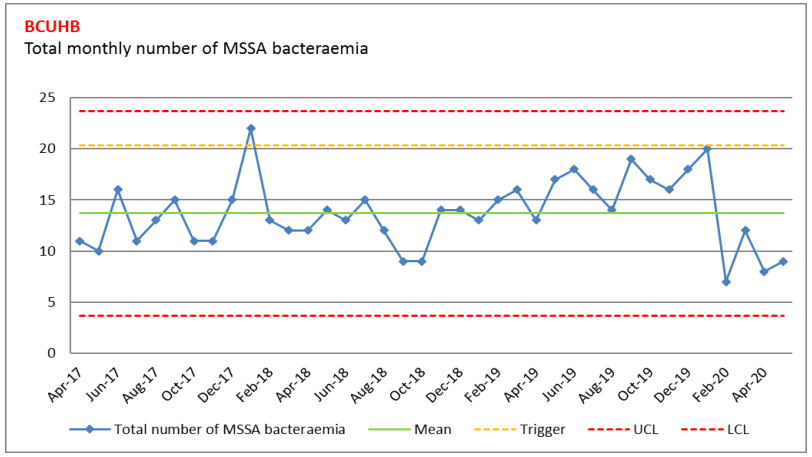
Overall BCU performance at 54% against an expectation of at least 75%. Performance at Wrexham Maelor Hospital is highest at 69%, with Ysbyty Gwynedd and Ysbyty Glan Clwyd at 46% and 47% respectively. However, it should be noted that performance against this measure is low across Wales at 58% when compared to an average of 78.2% for the rest of the UK.

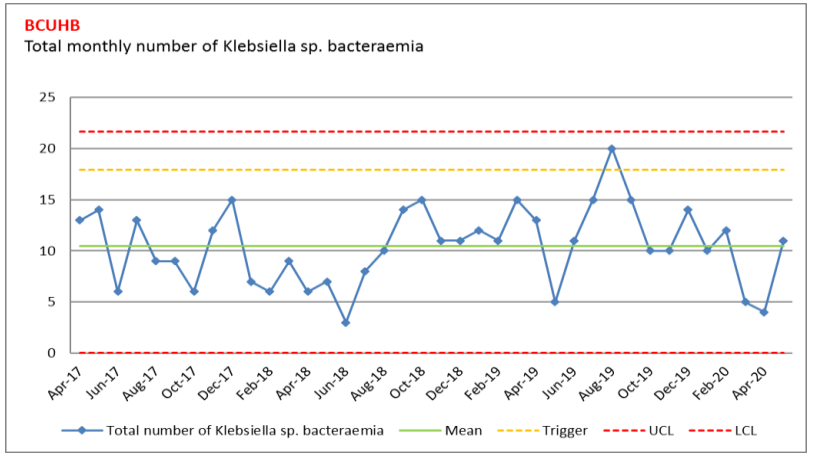
Essential Services Review 2 Chart

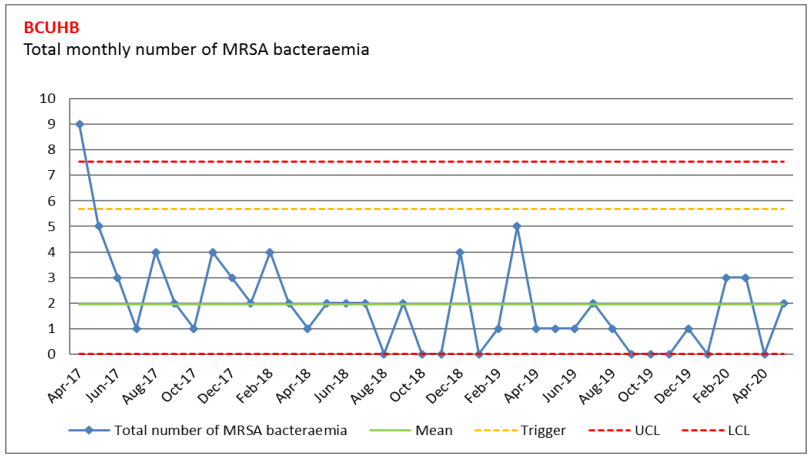


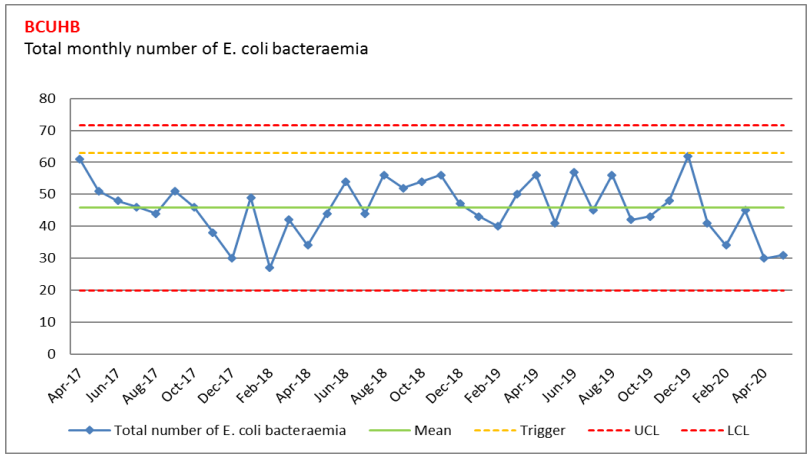
Quadruple Aim 2: Charts Infection Control page 1

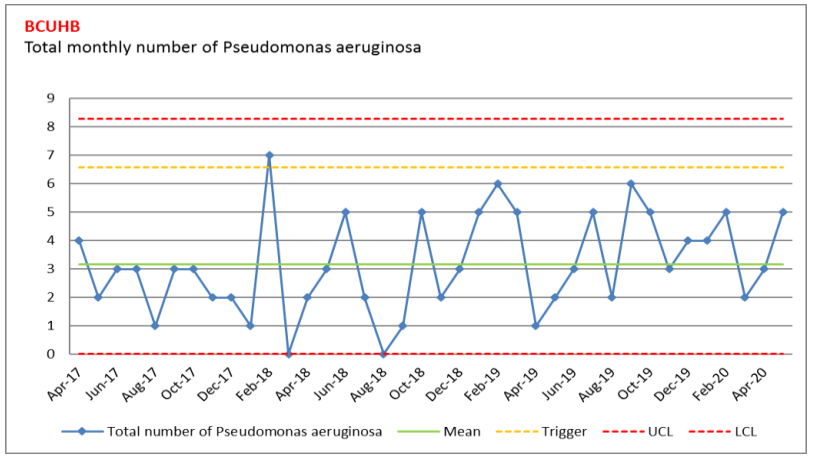




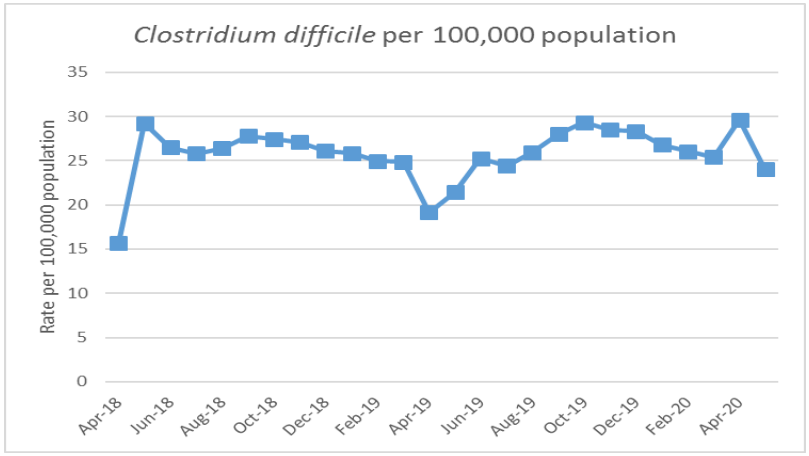


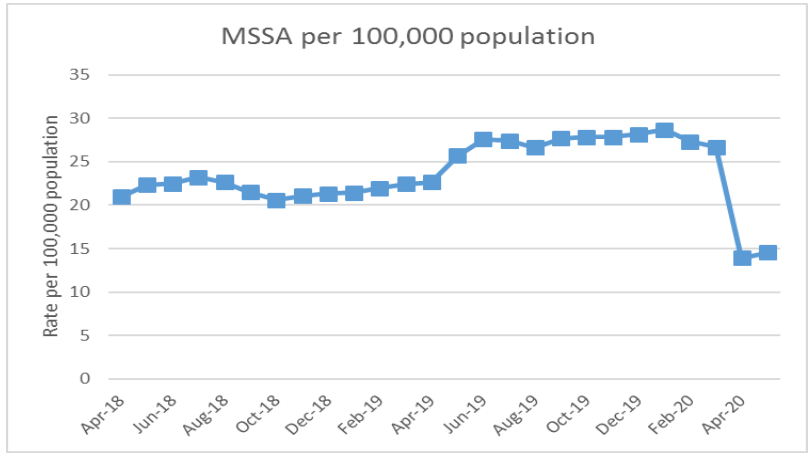


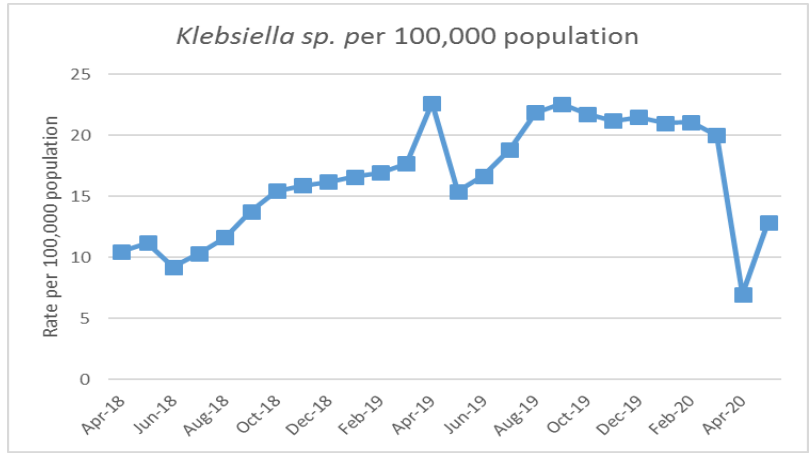


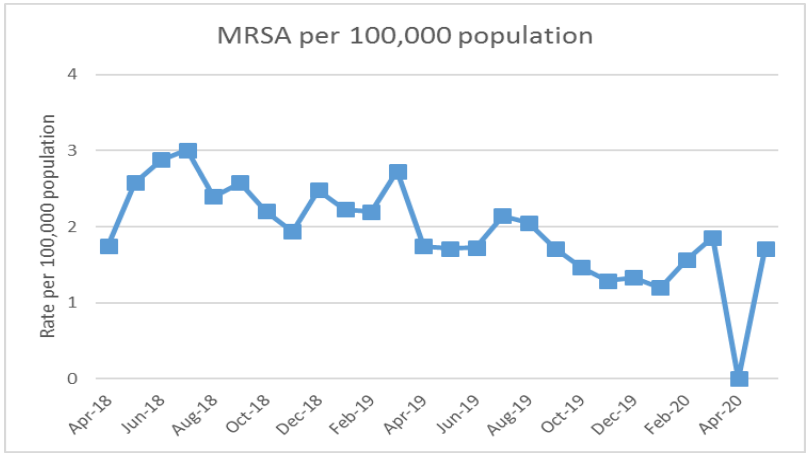


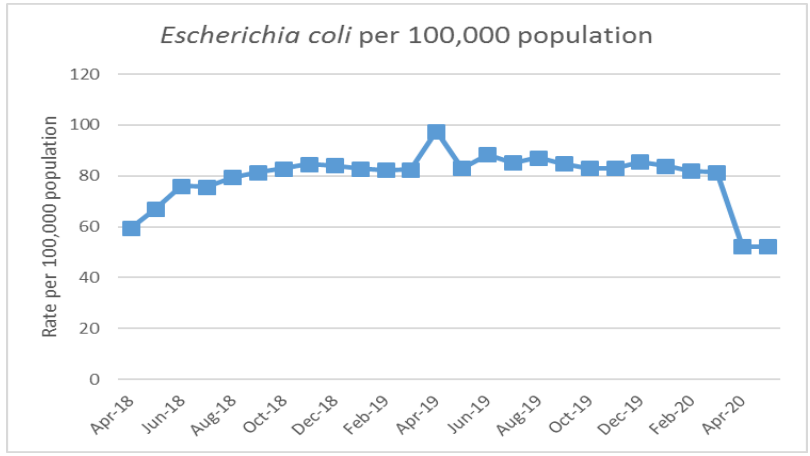
Quadruple Aim 2: Charts Infection Control page 2

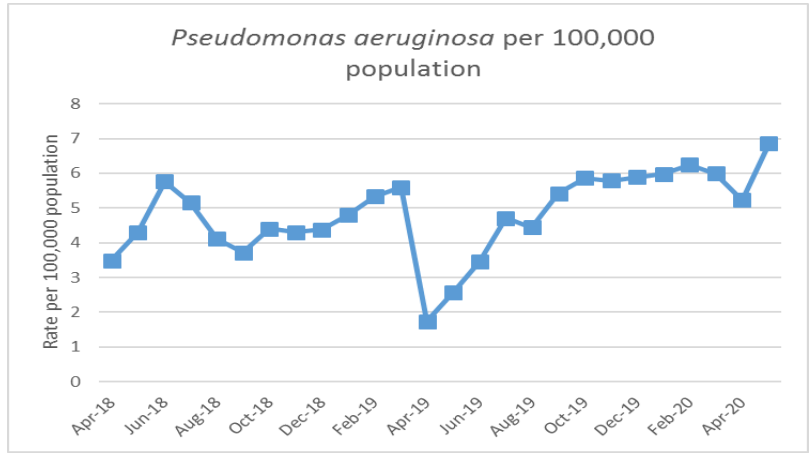




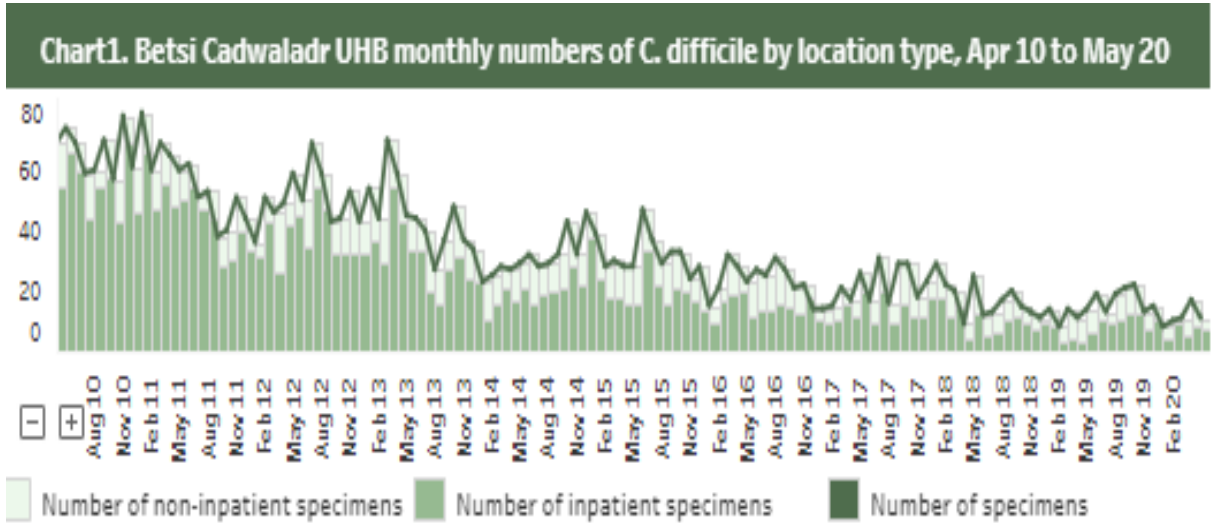


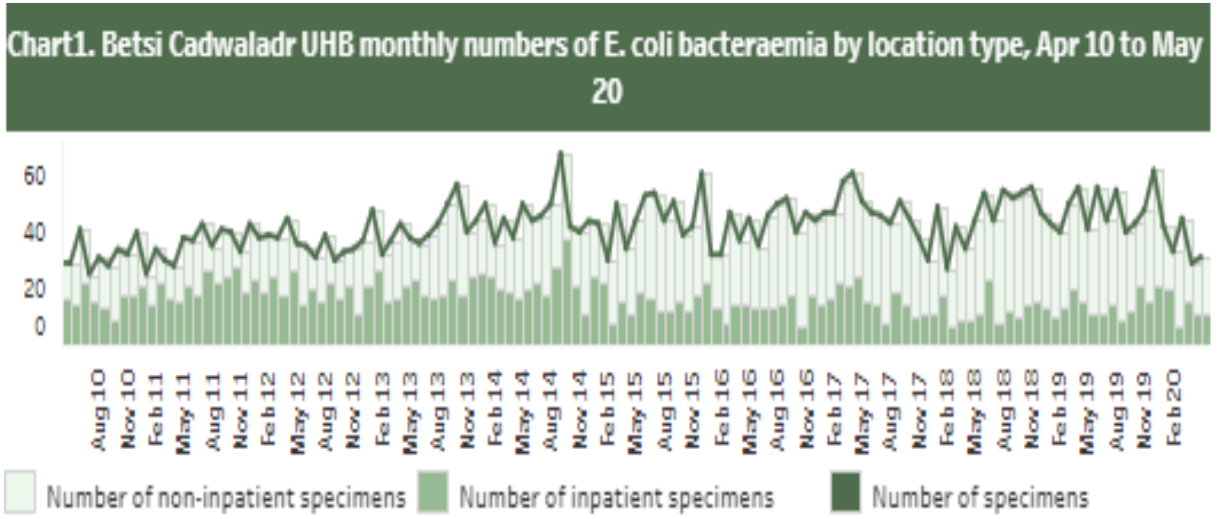


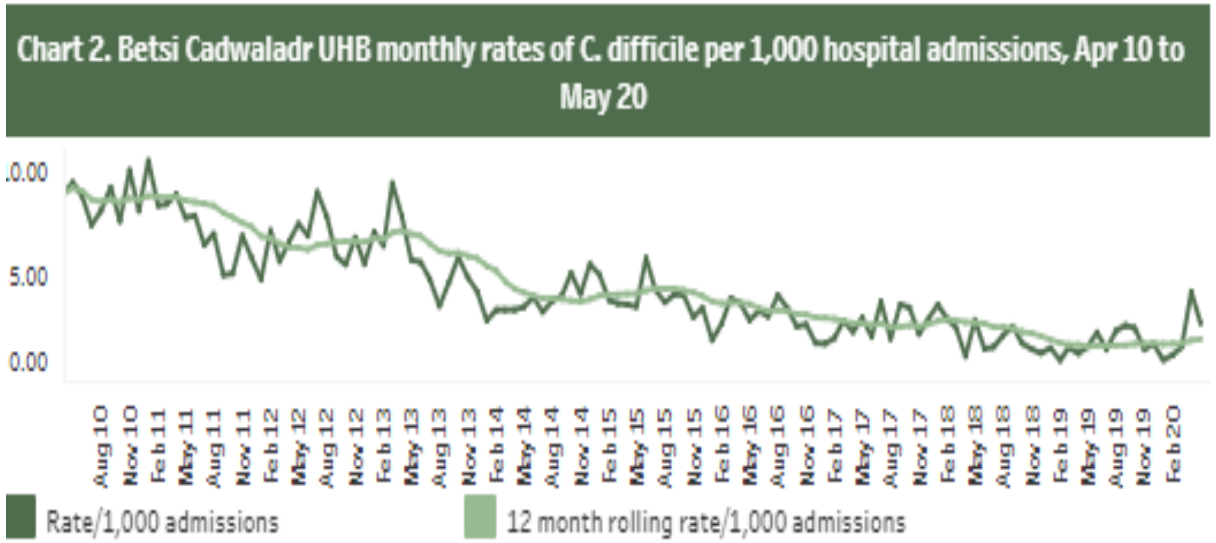


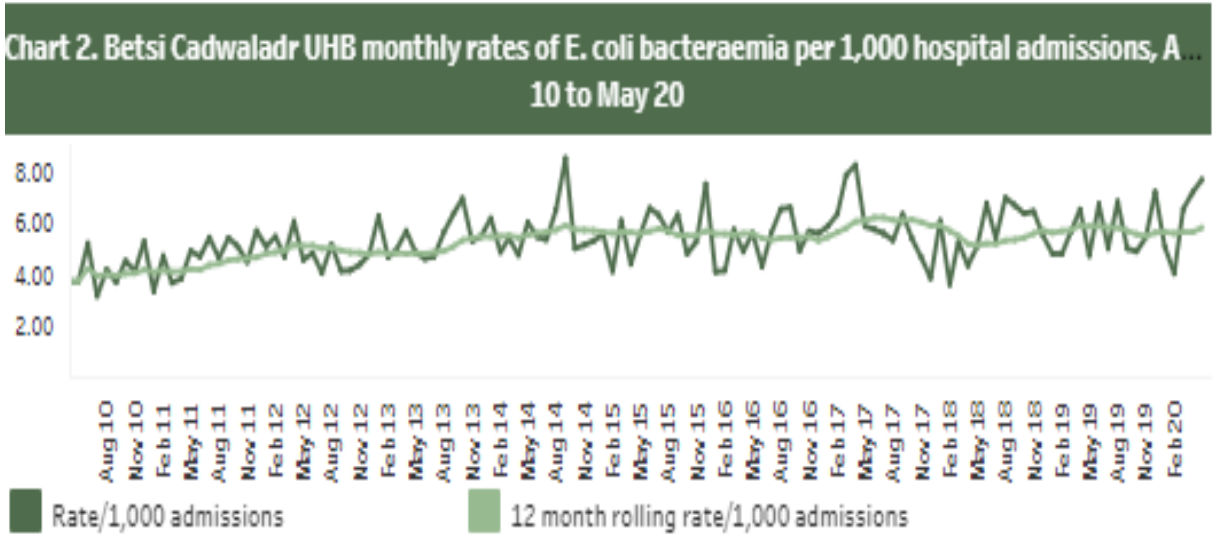


Quadruple Aim 2: Charts Infection Control page 3

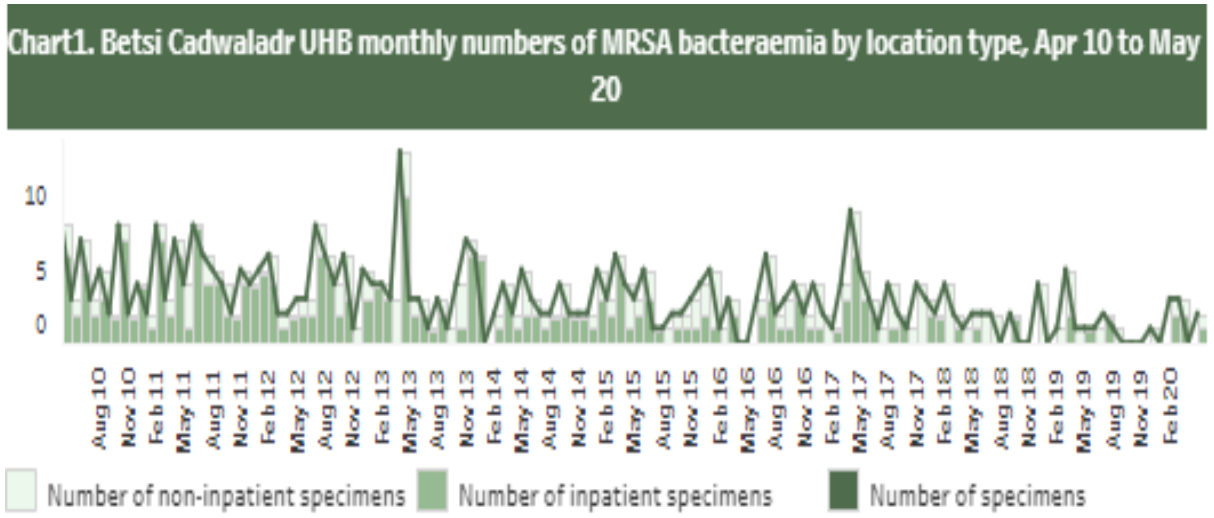


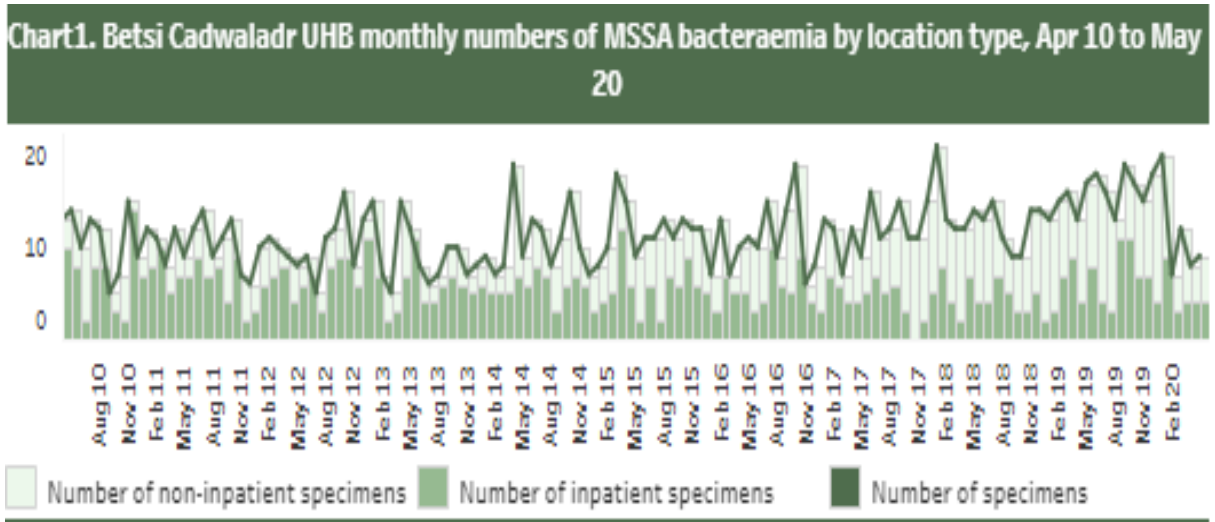


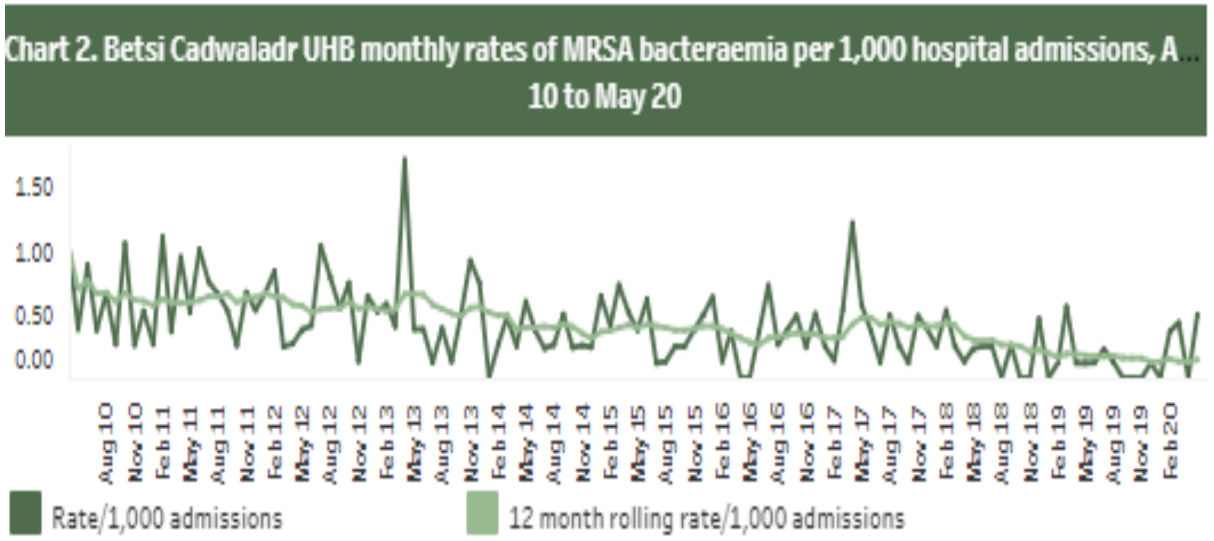


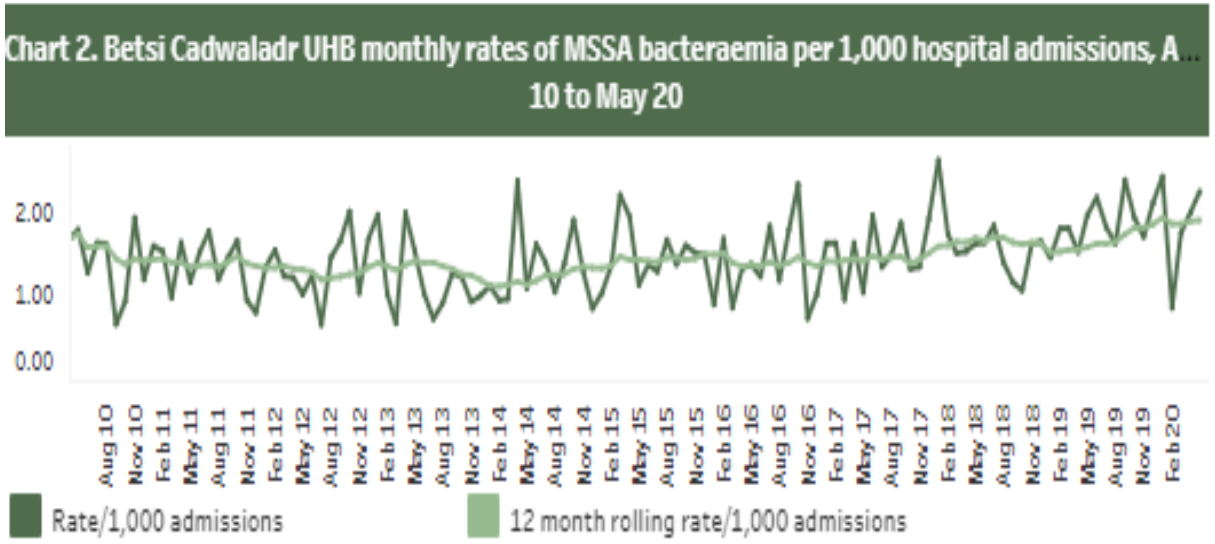


Quadruple Aim 2: Charts Infection Control page 4









Quadruple Aim 2: Charts Infection Control page 5

Chart1. Betsi Cadwaladr UHB monthly numbers of Klebsiella sp bacteraemia by location type, Apr 10 to May 20

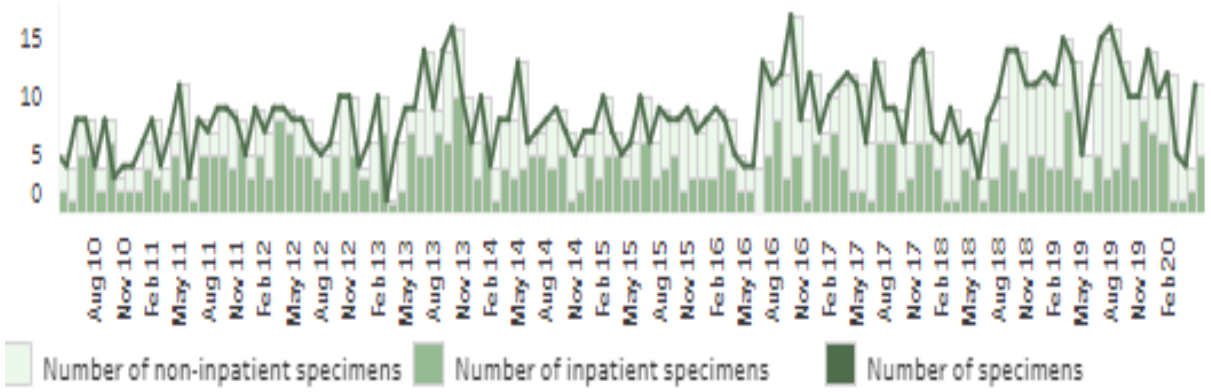


Chart1. Betsi Cadwaladr UHB monthly numbers of P. aeruginosa bacteraemia by location type, Apr 10 to May 20

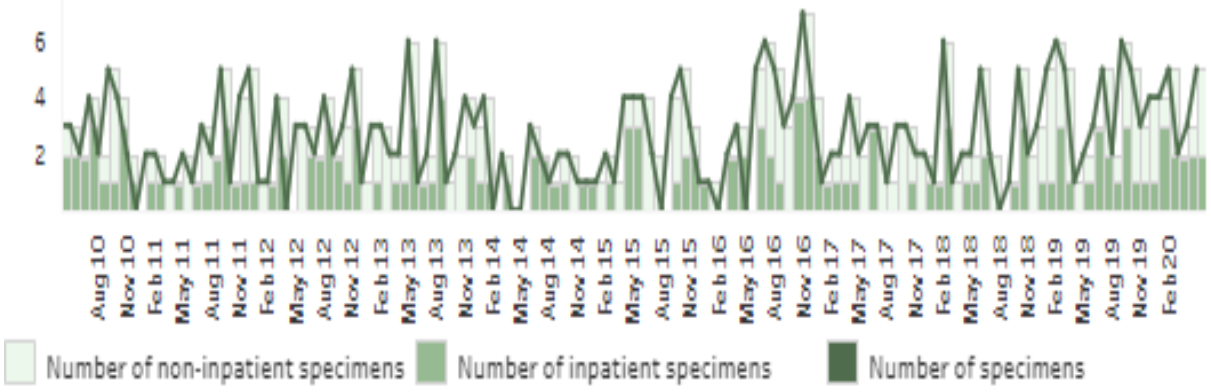


Chart 2. Betsi Cadwaladr UHB monthly rates of Klebsiella sp bacteraemia per 1,000 hospital admissions, Apr 10 to May 20

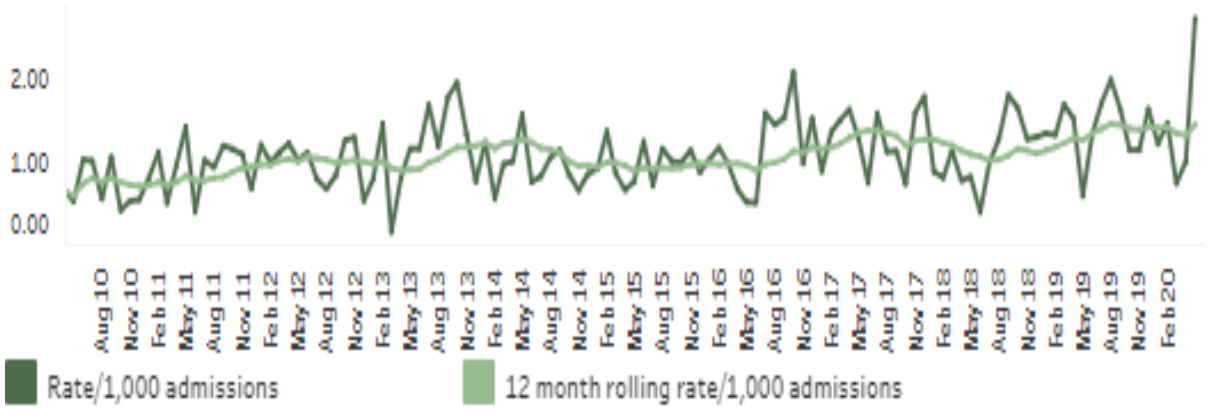
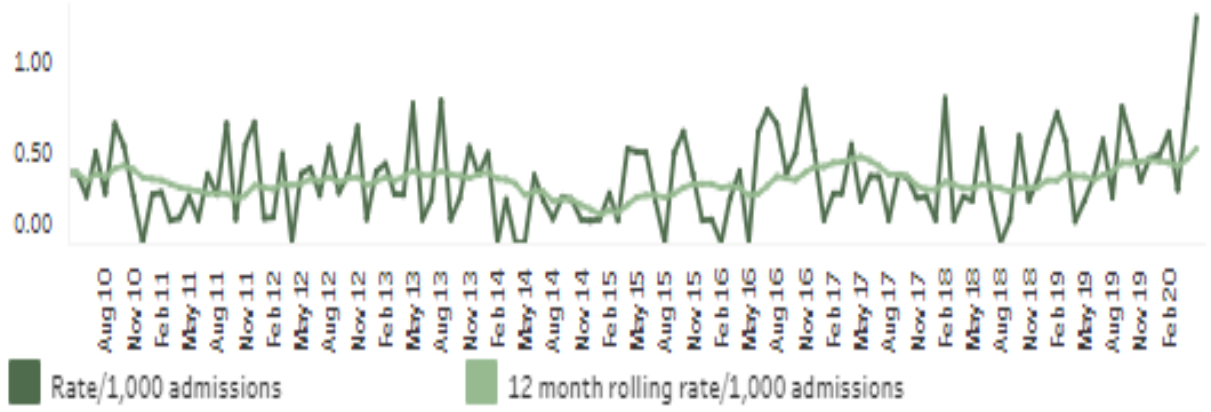
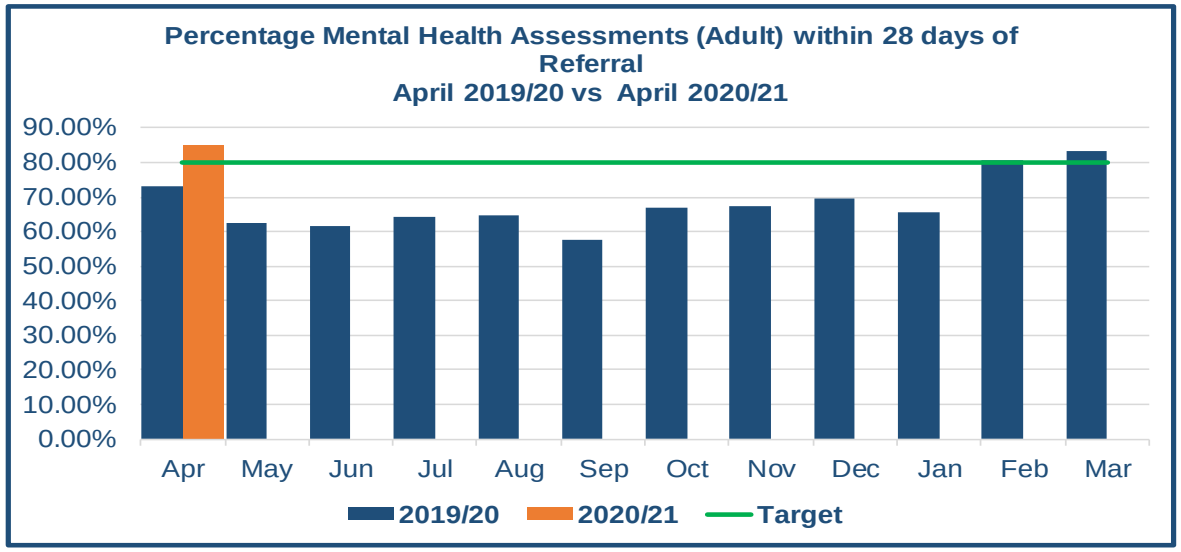
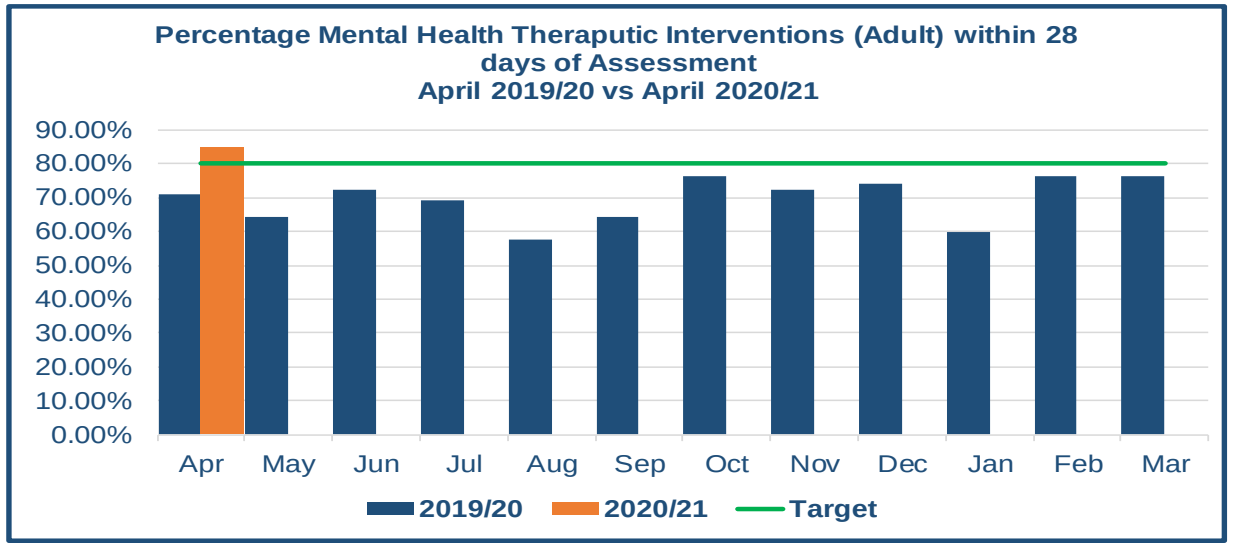


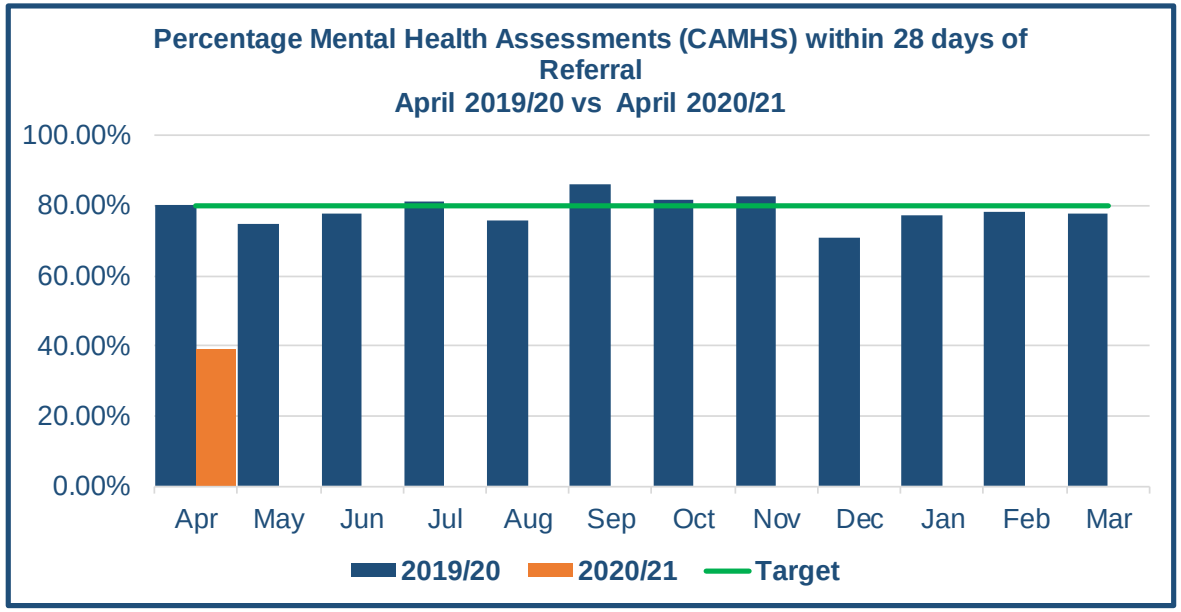
Chart 2. Betsi Cadwaladr UHB monthly rates of P. aeruginosa bacteraemia per 1,000 hospital admissions, Apr 10 to May 20

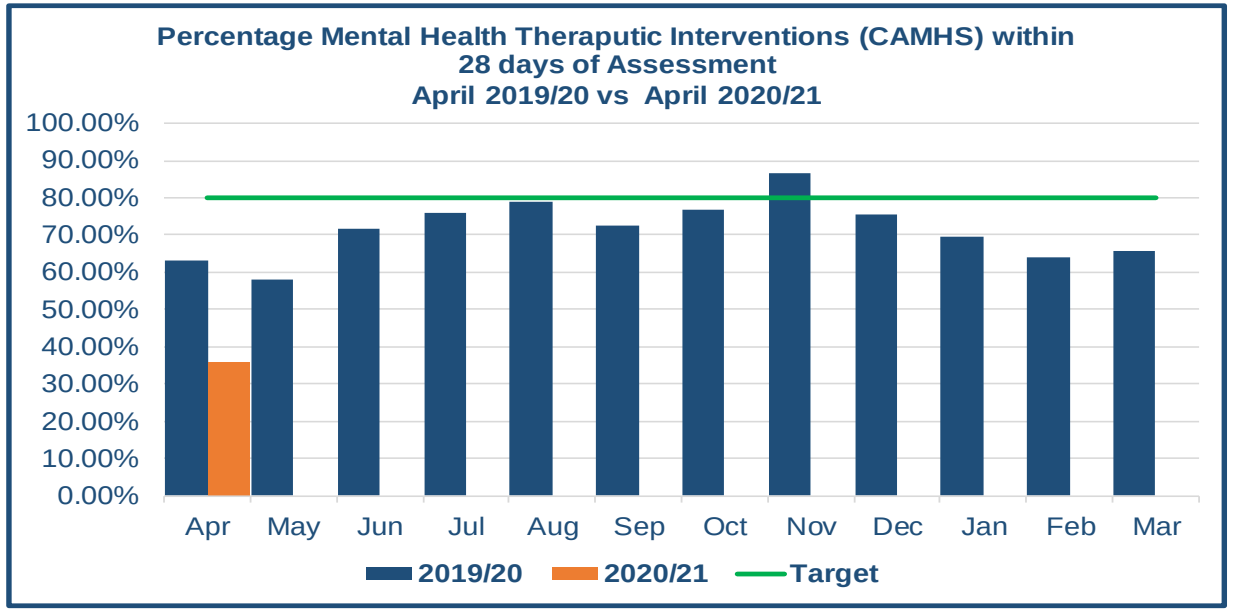


Quadruple Aim 2: Charts Mental Health and CAMHS

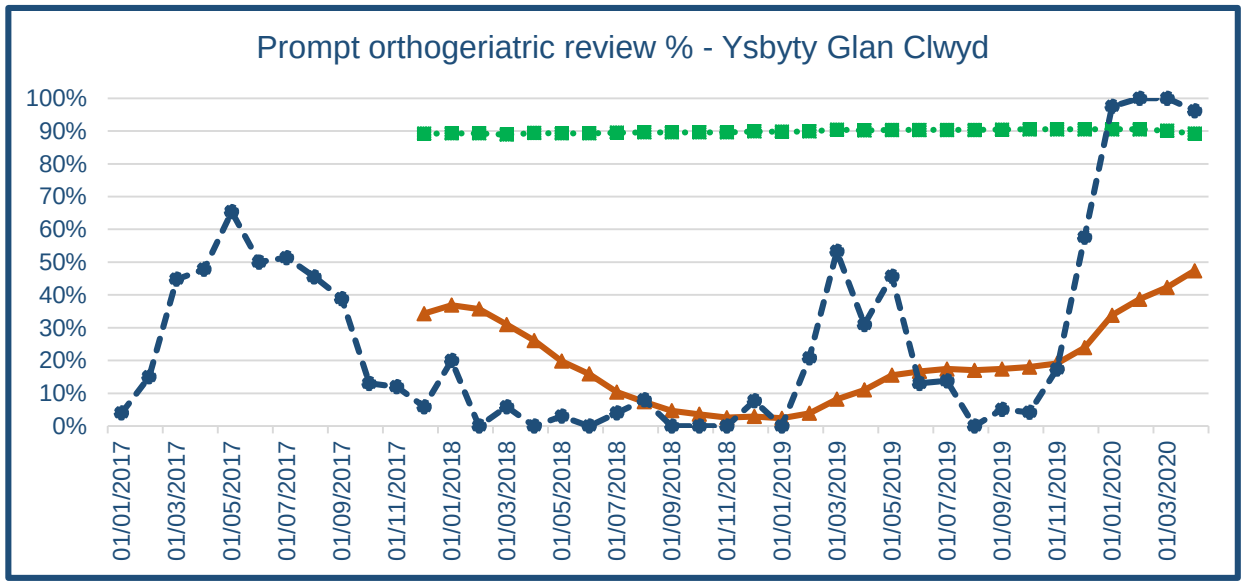


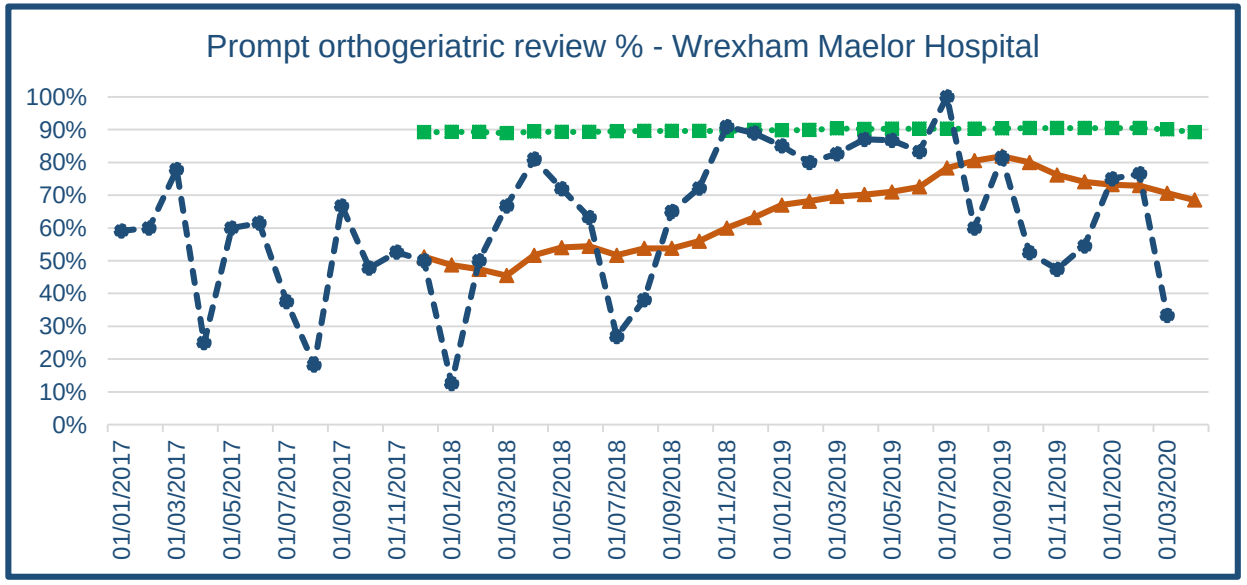


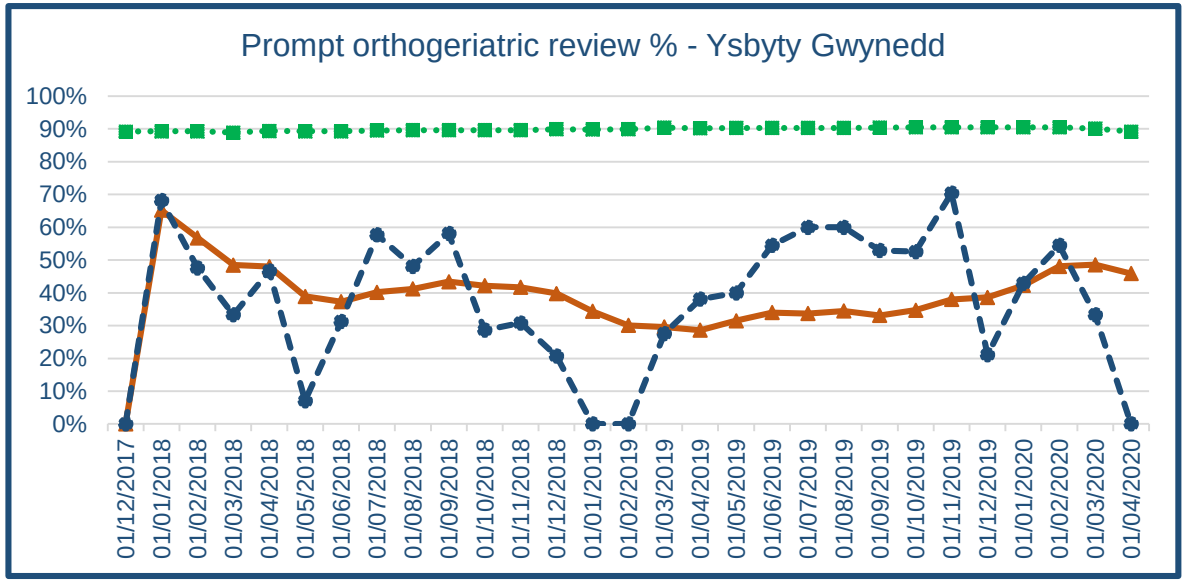




Quadruple Aim 2: Charts Fractured Neck of Femur







Key:

- ■ = UK Average (NHFD)
- ▲ = Annual (12 month) Average
- ● = Monthly

Source of Graphs and Data – National Hip Fracture Database (NHFD) – accessed 22nd June 2020

Appendix 1 - Quadruple Aim 1: Full List of Measures

Frequency	Measure	Target
Annual	Percentage of babies who are exclusively breastfed at 10 days old	**Annual Improvement**
Quarterly	3 doses of the hexavalent '6 in 1' vaccine by age 1	**95%**
Quarterly	2 doses of the MMR vaccine by age 5	**95%**
Annual	Healthy Child Wales Programme	**Improve**
Quarterly	Quit attempt via smoking cessation services	**5% annual target**
Quarterly	Smokers who are CO-validated as quit at 4 weeks	**40% annual target**
Annual	Alcohol attributed hospital admissions for individuals resident in Wales	**4 quarter reduction**

Frequency	Measure	Target
Seasonal	Uptake of the influenza vaccination among 65 and Over	**75%**
Seasonal	Uptake of the influenza vaccination among Under 65	**55%**
Seasonal	Uptake of the influenza vaccination among Pregnancy	**75%**
Seasonal	Uptake of the influenza vaccination among Staff	**60%**
Monthly	Care and treatment plan (aged under 18 years)	**90%**
Annual	Percentage (aged 65 years or over) who are diagnosed with dementia	**Annual Improvement**
Monthly	Care and treatment plan (aged 18 years and over)	**90%**

Appendix 1 - Quadruple Aim 2: Full List of Measures

Frequency	Measure	Target
Biannual	Qualitative report detailingadvancing equality and good relations	**N/A**
Biannual	Qualitative report for accessible communication and information for people with sensory loss	**N/A**
Biannual	Qualitative report – Improving Lives Welsh Government Programme	**N/A**
Biannual	Qualitative report to enable health and well-being of homeless and vulnerable groups	**N/A**
Monthly	Number of patients with Hepatitis C	**TBC**
Annual	Admissions for self-harm from children and young people	**Annual Reduction**
Monthly	Percentage of patients waiting less than 28 days (CAMHS)	**>= 80%**
Monthly	Percentage of mental health (Adult) assessments undertaken within 28 days	**>= 80%**

Frequency	Measure	Target
Monthly	Percentage of therapeutic interventions (Adult) within 28 days	**>= 80%**
Monthly	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	**>= 80%**
Monthly	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	**>= 80%**
Monthly	Number of health board mental health delayed transfer of care	**Reduction**
Quarterly	Number of potentially preventable hospital acquired thromboses	**Reduction**
Quarterly	Occupational therapy assessments	**TBC**

Appendix 1- Quadruple Aim 2: Full List of Measures – Page 2

Frequency	Measure	Target
Monthly	Cumulative rate of E-Coli cases per 100,000 population	**TBC**
Monthly	Cumulative number of E-Coli cases	**TBC**
Monthly	Cumulative rate of S.Aureus cases per 100,000 population	**TBC**
Monthly	Cumulative number of S.Aureus cases	**TBC**
Monthly	Cumulative rate of MRSA cases per 100,000 population	**TBC**
Monthly	Cumulative numberof MRSA cases	**TBC**
Monthly	Cumulative number of MSSA cases	**TBC**
Monthly	Cumulative number of Klebsiela cases	**TBC**
Monthly	Cumulative number of Aeruginsoa cases	**TBC**

Frequency	Measure	Target
Annual	Average rating (aged 16+) for the overall satisfaction with health services in Wales	**Improve**
Annual	Percentage of adults (aged 16+) satisfied about the care provided by their GP/family doctor	**Improve**
Annual	Percentage of adults (aged 16+) satisfied about the care received at an NHS hospital	**Improve**
Biannual	Qualitative report of implementation of the Welsh language actions	**N/A**
Biannual	Qualitative report Dementia Learning and Development Framework	**N/A**
Annual	Percentage of adults (aged 16+) who felt that they were treated with dignity and respect	**Improve**
Annual	Evidence of how NHS organisations are responding to service user experience	**N/A**
Monthly	Percentage of complaints that have received a final reply	**75%**
Monthly	Number new never Events	**0**

Quadruple Aim 3 & 4: Full List of Measures

Frequency	Measure	Target
Quarterly	Number of patients recruited in Health and Care Research Wales clinical research portfolio studies	**Improve**
Quarterly	Number of patients recruited in Health and Care Research Wales commercially sponsored studies	**Improve**
Monthly	Crude hospital mortality rate (74 years of age or less)	**Reduction**
Monthly	Percentage of deaths scrutinised by an independent medical examiner	**Improve**
Monthly	In-patients 'Sepsis Six' within one hour of positive screening	**Improve**
Monthly	Emergency Department 'Sepsis Six' within one hour of positive screening	**Improve**
Monthly	Patients meeting NICE head injury guidelines that receive a CT scan within 60 minutes	**TBC**
Monthly	Hip fracture that received an orthogeriatrician assessment within 72 hours age 60 and over	**Improve**

Frequency	Measure	Target
Quarterly	All new medicines recommended by AWMSG and NICE	**100%**
Quarterly	Total antibacterial items per 1,000 STAR-PUs	**Reduction**
Quarterly	Number of patients aged 65 years or over prescribed an antipsychotic	**Reduction**
Quarterly	Women of child bearing age prescribed valproate	**Reduction**
Quarterly	Opioid average daily quantities per 1,000 patients	**Reduction**
Quarterly	Quantity of biosimilar medicines prescribed	**Reduction**
Monthly	Procedures postponed for specified non-clinical reasons	**Reduction**
Monthly	Episodes clinically coded within one reporting month	**>= 95%**
Annual	Percentage of clinical coding accuracy	**Improve**

Further Information

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

- performance reference tables
- tolerances for red, amber and green
- the Welsh benchmark information which we have presented

Further information on our performance can be found online at:

- Our website www.pbc.cymru.nhs.uk
  www.bcu.wales.nhs.uk
- Stats Wales www.statswales.wales.gov.uk

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

ollow @bcuhb
ttp://www.facebook.com/bcuhealthboard

Cyfarfod a dyddiad: **Meeting and date:**	**Quality, Safety and Experience Committee (QSE)** **3.7.20**
Cyhoeddus neu Breifat: ***Public or Private:***	Public
Teitl yr Adroddiad **Report Title:**	Quality, Safety and Experience Committee (QSE) Corporate Risk and Assurance Framework Report
Cyfarwyddwr Cyfrifol: **Responsible Director:**	CRR02 - Executive Director of Nursing and Midwifery CRR03 - Director of Primary and Community Care CRR05 - Executive Director of Nursing and Midwifery CRR13 - Director of Mental Health and Learning Disabilities. CRR16 - Executive Director of Nursing and Midwifery CRR20 - Executive Director of Workforce and Organisational Development CRR21 - Executive Director of Workforce and Organisational Development CRR22 - Executive Director of Nursing and Midwifery CRR23 - Executive Director of Workforce and Organisational Development CRR24 - Executive Director of Workforce and Organisational Development CRR25 - Executive Director of Workforce and Organisational Development CRR26 - Executive Director of Workforce and Organisational Development CRR27 - Executive Director of Nursing and Midwifery CRR28 - Executive Director of Nursing and Midwifery CRR29 - Executive Director of Public Health
Awdur yr Adroddiad **Report Author:**	Justine Parry, Assistant Director of Information Governance & Risk. Mr David Tita, Head of Risk Management
Craffu blaenorol: **Prior Scrutiny:**	The full Corporate Risk and Assurance Framework (CRAF) is scrutinised by the Health Board twice per year and is published on the Board's external facing website. Individual risks are allocated to one of the Board's Committees for regular consideration and review. This report has been approved for submission to the Committee by the Deputy Chief Executive / Executive Director of Nursing and Midwifery.
Atodiadau **Appendices:**	Appendix 1 - Details of the Corporate Risk Register Report Appendix 2 - Details the new risk for consideration for inclusion onto the CRR.

Argymhelliad / Recommendation:

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

1. Consider the relevance of the current controls in place.
2. Review the actions in place and consider whether the risk scores remain appropriate for the present risks in line with the Health Board's risk appetite.

3. Approve the actions that have been completed and turned green so that they could be archived and replaced with new ones as deemed appropriate.
4. Approve an extension to the target risk dates for the following Health & Safety risks (CRR20, CRR21, CRR23, CRR24, CRR25 and CRR26) as per each request articulated below.
5. Approve and recommend the Corporate Risk Register (CRR) to the Audit Committee for approval and to gain assurance that risks articulated on it are managed in line with the Health Board`s risk management strategy and best practice.

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

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

Sefyllfa / Situation:

The continuous negative impact on the Health Board`s resources, strategy, tactics and operations triggered by the current prevailing Covid-19 situation underlines the need for strengthening and improving its risk management practice and ecosystem. This does not only thrust effective risk management at the heart of the Health Board`s approach to managing Covid-19 in continuously ensuring the safe delivery of its operations, business sustainability and financial viability but underlines the need to tap into the `upsides` or benefits of appropriate, comprehensive and dynamic risk management.

While this coversheet articulates the key highlights/progress and changes captured in each risks, Appendix 1 presents details of each of the risks on the CRR allocated to the Quality, Safety and Experience Committee (QSE). Updates captured as a result of the review and scrutiny of this corporate risk register (CRR) report will be presented to the Audit Committee for further scrutiny and assurance.

Cefndir / Background:

As part of the Health Board`s continuous drive to improve its risk management landscape including culture, system and processes, three very significant improvements have been made to this CRR report. These are:

1. A re-designed new template for capturing the Health Board`s risks which are on its CRR.
2. Inclusion of the Health Board's Risk Appetite level for the type of risk captured.
3. Optimise the use of the Health Board`s Risk Management action module on Datix by including a specific table in the CRR to facilitate the robust capturing of risk response plans or actions being implemented to support attaining target risk score.

The re-designed template for capturing risks on the CRR gains much in a better layout, clarity, brevity and simplicity with a dedicated section for articulating actions that are then transferred onto the risk management action module on Datix. The action section which comprises the actions that were in the further action section of Datix, now has due dates, action leads/owners, expected completion date and progress and comment sections included.

The use and optimisation of the Health Board`s Risk Management action module on Datix will ensure that actions on risk response plans are more robustly articulated on Datix with clearly specified timescales and owners. This will also ensure that actions don`t remain indefinitely on the CRR as well as improving accountability, scrutiny and invigorate our risk management governance culture.

Asesiad / Assessment & Analysis

The QSE held on the 5th May 2020 and after reviewing and scrutinising their risks advised on the following two key aspects: -

- That the CRAF be fully refreshed and updated especially in light of Covid-19.
- Risks which have been opened on it for many years be re-considered within the wider context of understanding why commensurate progress hasn`t been made in mitigating and reducing them to their target score despite the many controls in place.

A workshop will be held with the Board in July to support the identification and articulation of the Health Board's objectives in line with its Annual Plan so that live and current risks to the achievement of those objectives are developed and the CRR cleansed and refreshed. In preparation, all Executive Directors are currently further reviewing the risks assigned to them prior to the workshop.

In summary, the following updates present changes that have been made to risks since the last CRR report was received by the QSE: -

- **CRR02 - Infection Prevention and Control.**
  Key progress: The mitigating controls have been updated as well as the further actions which have been assigned due dates, action owners and progress notes added to demonstrate progress with their implementation.

  Further progress on this risk notes the fact that there is daily review of PPE stock levels and continuous drive to review all national guidance in relation to Infection Prevention & Control (IPc), PPE and to track this in the PPE steering Group as well as to continue to promote and collate Fit testing data for assurance across the Health Board. It also notes that there is agreement at the Infection Prevention Steering Group (IPSG) to extend the annual work programme to March 21 while also underlining the fact that there is daily monitoring of Covid-19 prevalence and mortality including any HCAIs via IRIS.

  However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

- **CRR03 Continuing Health Care.**
  Key progress: The risk has been slightly revised to include a limited understanding of the Framework, rather than an inconsistent application. All actions being implemented have been assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. Updates on this risk note the CHC Framework has been and remains formally paused by Welsh Government hence there hasn`t been any change in the current score of this risk.

  It is however worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

- **CRR05 Potential inability to learn from patient safety, concerns and experience**
  Key progress: The title of this risk has been updated in line with feedback from the last QSE meeting and to incorporate learning from patient safety as well. Further actions for this risk have

been updated and assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. Updates on this risks have noted that as a result of Covid-19 pressures only essential work has been done and the progress on the process to re-design for revised PTR requirements paused. This will now be taken forward.

There has been no change to the current risk scoring.

- **CRR13 Mental Health Services.**
  Key progress: The further actions have been updated and assigned due dates and action owners. It has been reviewed to reflect the following agreed service priorities which are being implemented to support achieving the target risk score. The description of this risk has also been updated to remove reference to `at all levels` as per the recommendation from one of the previous QSE meetings.

  A Task and Finish Group has also been established to develop the evidence base to support progress against defined priorities for this risk. However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

- **CRR16 Safeguarding**
  Key progress: This risk has been updated to cover the whole safeguarding spectrum, while all its actions have also been assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. Updates note the fact that, an internal audit of Corporate Safeguarding in 2020 has reviewed the BCU`s Corporate Safeguarding Governance and reporting arrangements. The audit has achieved a rating of full assurance with no recommendations identified. This outcome alone would have enabled the service to propose a reduction in the current risk score, however, as a result of the changes in BCUHB clinical services due to the National Covid-19 guidance and mandate, the re-deployment of key staff (HV/SN) and the recognised reduced access to vulnerable people throughout our service provision, the current score remains unchanged.

  The target score for this risk has been set at 12 which is outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. Updates on the risk reflect the fact that the target risk for Safeguarding may remain at 12 due to the high associated risks with this subject area, the complexity and the unpredictability and recognised potential catastrophic outcomes, which could result in the death of a child or adult at the hands of a parent or carer or other. No amount of intervention, governance or assurance processes will remove the possibility and reduce the impact of the outcome, when a death is caused by harm and abuse. This is evidenced in the National investigations and reviews, which recognise safeguarding is unpredictable, very high risk and risk can never be totally eliminated. It is therefore advisable for the Committee to consider the management of this risk outside of its risk appetite threshold.

- **CRR20 Security Risk**
  Key progress: This risk has been updated to include the impact description. Further actions have also been assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. Updates on this risk have raised ongoing concerns with the

volume of violence and aggression incidents occurring, the lack of control over contractors and some concerns around the central management of Security across BCU.

However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

The Committee is also requested to approve an extension to the target risk date for CRR20 from 1st November, 2020 to 31st March 2021 subject to approval of the two business cases submitted, and a review of COVID-19 impact over the coming months.

- **CRR21 Health & Safety Leadership and Management**
  Key progress: The further actions have been updated and assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. More than 50% of the actions identified in further mitigating and managing this risk have been completed. Updates on this risk include the fact that the service has been unable to continue with the action plan due to Covid-19 priorities. The service has therefore organised a workshop to review how the action plan and priorities are to be implemented with limited resources.

  However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

  The Committee is also requested to approve an extension to the target risk date for CRR21 from 1st November, 2020 to 31st March 2021 subject to approval of the two business cases submitted, and a review of COVID-19 impact over the coming months.

- **CRR22 Potential to compromise patient safety due to large backlog and lack of follow-up capacity.**
  Key progress: The further actions have been updated to include assigned due dates and action owners. Updates include the fact that it was agreed in the QSG that rather than revise this risk, a new one should be developed to reflect the wider concerns around the backlog and lack of follow-up as these are set to increase due to the pressures generated by Covid-19.

  However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

- **CRR23 Asbestos Management and Control**
  Key progress: The further actions have been updated and assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. Updates by Health & Safety note the fact that due to Covid-19 priorities, re-surveying of premises has been postponed and will be taken forward by Estates and Facilities.

  It is however worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

The Committee is also requested to approve an extension to the target risk date for CRR23 from 2nd November, 2020 to 31st March 2021 subject to approval of the two business cases submitted, and a review of COVID-19 impact over the coming months.

- **CRR24 Contractor Management and Control**
  Key progress: The further actions have been updated and include assigned due dates and action owners. Updates for this risk note the fact that, work on the work stream linked to it has not progressed further due to pressures generated by Covid-19, although a draft Contractor Procedure (written document) has now been implemented (March 2020).

  However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

  The Committee is also requested to approve an extension to the target risk date for CRR24 from 1st December, 2020 to 1st December 2021 to enable the controls and actions to be robustly implemented as we emerge from Covid-19 and gradually return to business as usual.

- **CRR25 Legionella Management and Control**.
  Key progress: The further actions have been updated and include assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. Updates include the fact that this risk remains significant, particularly when buildings and premises have not been used and we cannot clearly evidence that legionella management and control is robustly in place.

  However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

  The Committee is also requested to approve an extension to the target risk date for CRR25 from 30th November, 2020 to 31st March 2021 subject to approval of the two business cases submitted, and a review of COVID-19 impact over the coming months.

- **CRR26 Non-Compliance of Fire Safety Systems**
  Key progress: The further actions have been updated and include assigned due dates and action owners. A recent Fire Report from YG has indicated short-falls in compartmentation and structural integrity hence a significant risk arises from that premises. As fire risks are managed via the Fire Safety Management Group, the Fire Authority will be informed to ascertain whether Action Plans and time scales are acceptable or not.

  However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

  The Committee is also requested to approve an extension to the target risk date for CRR26 from 1st November, 2020 to 31st March 2021 subject to approval of the two business cases submitted, and a review of COVID-19 impact over the coming months.

- **CRR27– Risk to public health and safety arising from an outbreak of COVID-19 and demand outstripping organisational capacity.**
  Key Progress: The further actions have been updated and include due dates, action owners. This risk focuses on highlighting the potential impact to the health and safety of staff and patients from the outbreak of Covid-19 as this could unleash pressure and a mismatch between demand and capacity as well as negatively impact on the Health Board`s limited resources.

- **CRR28 - Risk of infection from COVID-19 to staff and patients as a result of inadequate supply, quality or usage of PPE.**
  Key Progress: The further actions have been updated and include due dates, action owners. Updates include the need to effectively mitigate and manage this risk so as to protect the health, well-being and safety of both staff and patients.

  This risk is regularly reviewed and monitored by the PPE Work-stream. It is worth noting that there has been no change in its current score.

NB: Details of the full CRR are captured in Appendix 1 while Appendix 2 provides details of a new risk being presented for consideration and recommendation for inclusion onto the CRR.

Closed Risk:
No risks allocated to the Committee have been agreed to be closed since the last CRR report was presented to the Board.

New Risks added since the last report:

- **CRR29 - Timely access to care homes.**
  Key progress: This newly identified risk has been escalated for inclusion onto the Corporate Risk Register. Mitigating controls have been put in place and further actions have also been assigned due dates, action owners and progress notes added to demonstrate progress with their implementation. 50% of the actions identified in further mitigating and managing this risk have been completed.

  However, it is worth noting that the target score for this risk has been set outside the Health Board`s agreed risk appetite as it should have been positioned anywhere ranging from 1-6. It is therefore advisable for the Committee to scrutinise and advise on further action required.

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5			CRR03	CRR22 CRR26	
	Likely - 4			CRR05	CRR13 CRR16	CRR20 CRR21 CRR23 CRR24 CRR25 CRR27 CRR29
	Possible - 3				CRR28	CRR02
	Unlikely - 2					
	Rare - 1					

Strategy Implications
In line with the Health Board's Risk Management Strategy, all corporate risks are reviewed by a dedicated Committee of the Board which provides a structure and framework to consistently manage both strategic and operational risks as drivers for better decision making. These risks will identify the risks associated with the delivery of the Health Board's objectives as defined in the 3-year plan and annual plans.

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.

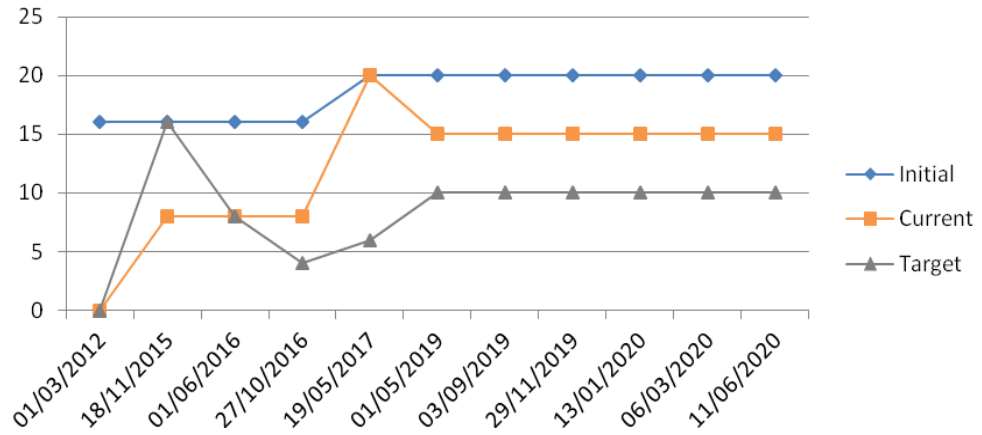
Risk Analysis
No risks have been identified from crafting this report as the risk of inaction is far greater than that of positive engagement with its content.

Legal and Compliance
This CRR report which will be periodically shared with the Board is intended to provide assurance.

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

Appendix 1 - Details of the Corporate Risk Register

CRR02	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 11 June 2020
	Risk: Infection Prevention & Control	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 31 December 2020
There is a risk that patients will suffer harm due to healthcare associated infection. This may be caused by a failure to put in place systems, processes and practices that would prevent avoidable infection. The impact of this may increase morbidity and mortality, increase admissions and longer length of stay, increase treatment costs, reputational damage and loss of public confidence.		



	Impact	Likelihood	Score
Initial Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score (Risk Appetite – *low level)*	5	2	10
Movement in Current Risk Rating Since last presented to the Board in April 2020	*Unchanged*		

Controls in place	Assurances
1. Infection Prevention Sub-Group scrutinise trajactories and performance through the regular cycle of business, quarterly and annual reports to Quality and Safety Group. 2. Surveillance systems, scrutiny and policies/SOPs in place for key infections, with data presented through the governance route to Board.	1. WG review of decontamination. 2. Demonstrable improvement in line with National Benchmarks. 3. CHC Bug watch visits.

3. Areas and Secondary Care sites governance arrangements are in place. 4. Local scrutiny meetings to review infections and learning from each site/area in place. 5. Continued progress on ANTT staff training, with key trainers in place, increased focus on medical staff supported by MDs, competencies held by individuals managers. 6. External review performed August 2017; report on further actions presented to Board. Second review report received in August 2019 shows improvement, as does the internal audit on Safe Clean Care (SCC) assurance in June 2019. 7. SCC Programme launched 29-01-18. 8. CAUTI snapshot carried out in September 2019. 9. Deep dive considers every 6 organisms under WG scrutiny. 10. Fit Testing programme and database now coordinated via IPC service. 11. Decontamination role for B7 agreed to support the service April 2020. 12. Update IPC/PPE web pages for COVID 19.	4. HSE reviews. 5. Internal Audits of Governance Arrangements.

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3 4 5 6 7	PR1	Leadership

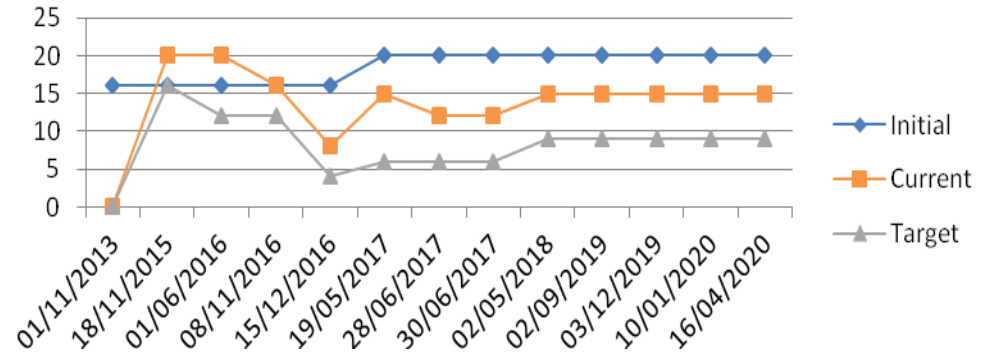
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**Completion date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve	12481	Cannula devices and documents approved for distribution across the HB.	Mrs Amanda Miskell, ANS Infection Prevention	29/06/2020	29/06/2020		

target risk score	12478	Scrutinise every avoidable infection and lessons learnt from these are shared formally from Post Infection Reviews and Deep Dives.	Mrs Amanda Miskell, ANS Infection Prevention	12/12/2020	12/12/2020		
	12479	Continue work on influenza preparedness and response for Winter 20/21 taking the learning from Covid-19.	Mrs Amanda Miskell, ANS Infection Prevention	28/12/2020	28/12/2020		
	12480	Educational event and Link practitioners in place December 2020.	Mrs Amanda Miskell, ANS Infection Prevention	28/12/2020	28/12/2020		
	12475	Implement the other actions identified in the 2019-20 annual infection prevention programme.	Mrs Amanda Miskell, ANS Infection Prevention	29/12/2020	29/12/2020		
	12476	Implement actions in response to Welsh Government Antimicrobial Delivery Plan, relevant Welsh Health Circulars and in response to multi-drug resistant organisms. Part of the ARK study and rollout.	Mrs Amanda Miskell, ANS Infection Prevention	29/12/2020	29/12/2020		
	12484	Review of all IP policies and	Mrs Amanda	29/12/2020	29/12/2020		

		SOPs	Miskell, ANS Infection Prevention				
	12485	Development of IP team in 2020.	Mrs Amanda Miskell, ANS Infection Prevention	29/12/2020	29/12/2020		
	12486	Reduce patient movement through the organisation and improve ability to trace back patients journeys through inpatient areas	Mrs Amanda Miskell, ANS Infection Prevention	30/12/2020	30/12/2020		
	12487	Introduce hand hygiene wipes for all patients in 2020	Mrs Amanda Miskell, ANS Infection Prevention	30/12/2020	30/12/2020		
	12482	Collaborative work with Continence, Tissue Viability and Pharmacy to address unwarranted variation and HCAIs.	Mrs Amanda Miskell, ANS Infection Prevention	30/12/2020	30/12/2020		
	12483	Improved visibility across the HB from IP service.	Mrs Amanda Miskell, ANS Infection Prevention	30/12/2020	30/12/2020		

	12477	Continue to progress key actions from Duerden and Jan Stevens reports 2016, 2017, 2019 in relation to Variation, Consultant Microbiologist staffing and capacity, Antimicrobial Stewardship, Estates and Facilities, policies and procedures and Safe Clean Care.	Mrs Amanda Miskell, ANS Infection Prevention	30/12/2020	30/12/2020		
	12473	Continue the implementation of SCC and IP via annual work programmes.	Mrs Amanda Miskell, ANS Infection Prevention	30/12/2020	30/12/2020		
	12474	Consider aligning SCC with IP Annual Work Programme.	Mrs Amanda Miskell, ANS Infection Prevention	30/12/2020	30/12/2020		

	Risk: Continuing Health Care	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 31 March 2021
There is a risk that the CHC National Framework is not complied with. This is due to limited understanding of the framework and inconsistent application. This could lead to poor patient experience, outcomes and value for money.		



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	3	5	15
Target Risk Score (Risk Appetite – *low level)*	3	3	9
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. National CHC Framework. (2014). 2. Area and divisional CHC team with local accountability. 3. Revised BCUHB CHC Improvement Group and CHC operational Group Reporting and Governance Framework agreed. 4. Annual WG self assessment. 5. Contracts and contract monitoring team in place. 6. CHC Contracts in place for all placements. 7. Partnership established with the National Commisioning Collaborative Unit to oversee overarching strategy development improving quality, experience and value.	1. Regular meetings with Regulators (CSSIW). 2.Inter-agency processes in place to review escalated concerns. 3. FNC Judicial Reviews of NHS Wales fee setting methodology implemented. 4. National reporting on CHC placements.
Links to	

Strategic Goals	Principal Risks	Special Measures Theme
2 3 4 5 6 7	PR1	Strategic and Service Planning

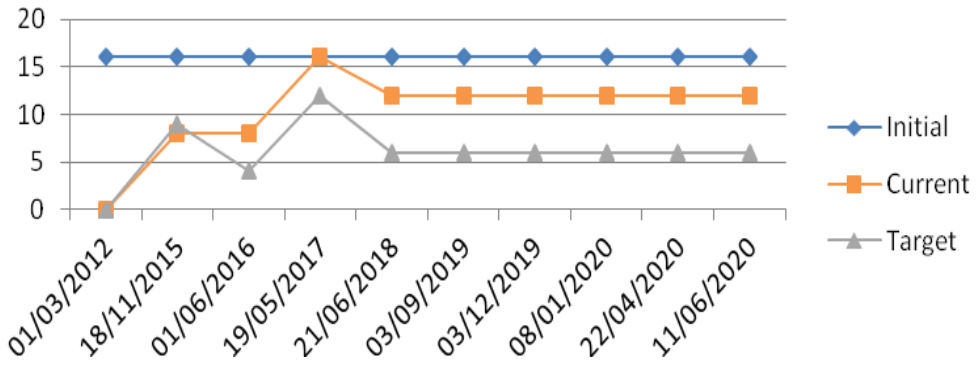
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	Completion date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12291	Progress programme of CHC support with NCCU, to include focus on training and development, data and performance management, standard operating procedures, stakeholder engagement and realignment of CHC within the Health Board.	Kathryn Titchen, Commissioning Manager CHC	31/03/2021	31/03/2021	On hold by direction of WG pausing all CHC activities to support Covid-19 responses. CHC overarching PID in final phases prior to pause status.	
	12292	Development of dashboard KPI's for CHC with Broadcare.	Kathryn Titchen, Commissioning Manager CHC	01/07/2020	01/07/2020	CHC as a case management tool, activity and performance tool is moving to a validation/ maintenance phase. There has been some delay as additional operational and	

						covid-19 dashboard development has taken precedence.	
	12293	Monthly exception reporting.	Kathryn Titchen, Commissioning Manager CHC	31/03/2021	31/03/2021	On hold; Monthly CHC exception reporting now temporarily superseded by covid-19 monitoring please see CRR29.	
	12294	Develop CHC commissioning strategy	Kathryn Titchen, Commissioning Manager CHC	31/03/2021	31/03/2021	Developed CHC strategy and overarching CHC PID On Hold and now focusing on Care Home Covid-19 strategy in line with WG directions for CHC pause.	
	12341	Develop and finalise the joint contracting process for providers in formal escalation	Kathryn Titchen, Commissioning Manager CHC	31/03/2021	31/03/2021	On Hold; Joint escalation for non covid-19 issues. Joint MDT Care Home support for Covid-19 in progress as part of the care home escalation plans.	
	12342	Additional COVID financial risk;	Kathryn Titchen, Commissioning	01/07/2020	01/07/2020	HB's have been given additional	

		Active participation at national levels into the possible financial assistance from WG. BroadCare case management software upgraded to include new pathways for clear tracing of activity. Home first Dashboards collating all CHC discharge activity and links into planning and Informatics to capture all additional pathway impacts to be able to reconcile additional costs.	Manager CHC			cohorts of patients in the WG COVID discharge guidance to ensure step up and step down/ discharge homes are COVID transmission safe with no additional funding identified.	
	12343	Potential quality increased risks Linking with CIW and National Complex Care Leads represented on the National Collaboration Board for an Update from PHW/ WG and CIW regarding visitors into care home guidelines.	Kathryn Titchen, Commissioning Manager CHC	01/07/2020	01/07/2020	Covid-19 IPC measures have meant that there is vastly decreased monitoring and actual 'eyes on' care homes, residential homes and individuals in their own homes.	
	12344	Increased HB activity, responsibilities and work load (circa 4000 care home residents to 7000)	Kathryn Titchen, Commissioning Manager CHC	31/08/2020	31/08/2020		

CRR05	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 1 March 2012
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 11 June 2020
	Risk: Potential inability to learn from patient safety, concerns and experience	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 31 December 2020

There is a risk that the Health Board does not listen and learn from patient safety and experience due to the untimely management, investigation and subsequent improvement actions from concerns (incidents, complaints, claims, inquests). This could lead to repeated failures in quality and safety of care, poor patient experience, loss of organisational memory and reputational damage to the Health Board.



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	3	4	12
Target Risk Score (Risk Appetite – *low level)*	3	2	6
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Processes in place to manage concerns (incidents, complaints, claims, inquests) in accordance with PTR Regulations. 2. Corporate and divisional meetings to manage processes and cascade learning including daily reviews within divisions, weekly reviews within divisions and a weekly pan Health Board Incident and Complaint Review Meeting. 3. Reporting to share learning and monitor performance at divisional and pan Health Board levels; including divisional quality and safety reports, divisional patient experience reports and a Health Board monthly and quarterly Patient Safety Report and quarterly Patient Experience Report.	1. Welsh Risk Pool Reports. 2. Monthly review by Delivery Unit. 3. Public Service Ombudsman Annual Report, Section 16 and feedback from cases. 4. Regulation 28 Reports from the Coroner.

4. Harm Dashboards available for local clinical leaders to identify opportunities for learning and improvement. 5. Pan Health Board quality improvement collaborative programmes commenced based on identified risks including a Falls Collaborative, Sepsis Collaborative and a Healthcare Acquired Pressure Ulcer (HAPU) Collaborative. 5. Patient Safety and Experience Department in place to develop and manage processes and systems and offer advice and assurance – supported by divisional governance teams and linked to the BCU Quality Improvement Hub. 6. New Patient Advice and Liaison Service (PALS) fully resourced and launched in 2019. 7. Learning from Event (LfE) Reports prepared for all claims and redress cases. 8. The Head of Patient Safety is part of, and chairs, the All-Wales Redress Case Review Group enabling learning from across the country to be identified. The Patient Safety and Experience Department is represented at, and fully engaged in, each All-Wales concerns related network. 9. Training programme in place to support continued learning, delivered by the Patient Safety and Experience Department. 10. Patient Safety Alerts process in place to cascade learning across the Health Board. 11. Quality and Safety Group in place to oversee patient safety and to cascade learning from patient safety issues, and a Patient Experience Group in place to undertake the same for patient experience (divisions provide reports to both groups). 12 Joint protocol in place between Health Boards and Welsh Ambulance Service Trust to undertake joint investigations when appropriate. 13. Mortality review process in place to support learning from deaths. 14. Site audits by the Community Health Council (CHC) received through a single point of contact within the Health Board. 15. Inspections by Health Inspectorate Wales (HIW) received and coordinated through a single point of contact within the Health Board along with regular meetings with the HIW relationship manager.	

Links to

Strategic Goals	Principal Risks	Special Measures Theme
3 4 5 6	PR9 PR7 PR1	Leadership

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	Completion date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12349	Concerns processes (incidents, complaints, claims, inquests) being fully reviewed following appointment of the new Assistant Director of Patient Safety and Experience – full process re-design will take place throughout 2020 in co-production with stakeholders, building on national best practice.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	30/12/2020	30/12/2020	The work and deadline has been revised in light of COVID, as the work undertaken in early 2020 had to be suspended. Interim COVID PTR processes are in place based on guidance from Welsh Government	
	12350	Patent Safety Alert process to be moved to the Patient Safety and Experience Department allowing for greater integration of data/insight and activity.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	01/09/2020	01/09/2020	Responsibility transferred from OMD to PS&E however the work to review and improve the process has been revised in light of COVID.	

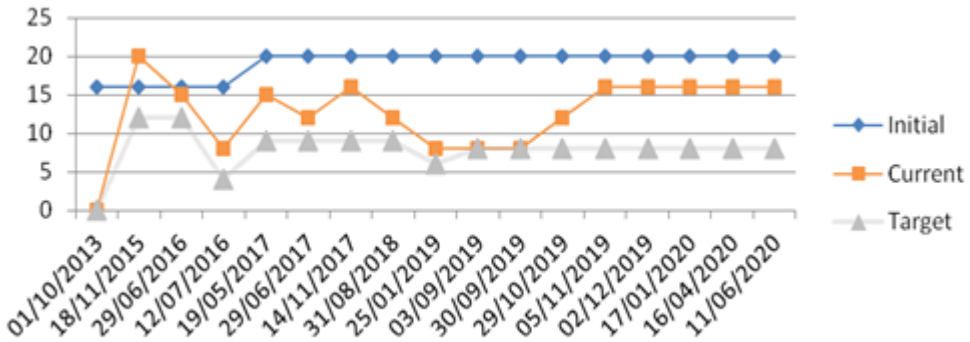
	12351	Development of a Patient Safety and Experience Learning Library on the intranet to further promote learning.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	30/12/2020	30/12/2020	The work and deadline to develop this new resource has been revised in light of COVID.	
	12352	Development of a Patient Safety and Experience Bulletin to further promote learning.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	30/12/2020	30/12/2020	The work and deadline to develop this new resource has been revised in light of COVID.	
	12353	Review and update of training and development with a particular emphasis on developing and embedding human factors and systems thinking.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	30/12/2020	30/12/2020	The work and deadline to develop this new resource has been revised in light of COVID.	
	12354	Implementation of new "Once for Wales" RLDatix concerns management system to aid learning across the Health Board and Wales.	Mr Matthew Joyes, Assistant Director of Patient	30/12/2020	30/12/2020	This is a two-year national programme. The national programme pan is being updated in light of	

			Safety & Experience			COVID so the delivery dates may change. An internal BCU quality systems group has been established to oversee Datix.	
	12355	Review of the weekly incident and complaint review meeting and development into a weekly Patient Safety Summit.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	30/12/2020	30/12/2020	The work and deadline to develop this new resource has been revised in light of COVID. This work is tied to the process changed listed above.	
	12356	Structure review within the Patient Safety and Experience Department to improve the focus and profile of patient safety and to integrate complaints with patient experience/PALS.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	30/12/2020	30/12/2020	The work and deadline to develop this new resource has been revised in light of COVID.	
	12357	Enhancement of the mortality review process to implement the new national Medical Examiner programme.	Mr Matthew Joyes, Assistant Director of Patient	30/12/2020	30/12/2020	The work and deadline to develop this process has been revised in light of COVID. Interim COVID mortality review processes	

			Safety & Experience			are in place based on guidance from Welsh Government.	
	12358	Workshop to be held with the Community Health Council to develop partnership working.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	29/01/2020	29/01/2020	Action has been completed.	

CRR13	**Director Lead:** Director of Mental Health and Learning Disabilities	**Date Opened:** 1 October 2013
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 11 June 2020
	Risk: Mental Health Services	**Date of Committee Review:** 5 May 2020

	Target Risk Date: 31 December 2020
There is a risk that patients receive inappropriate care within Mental Health Services due to failings in leadership and governance within the Division which could result in poor quality outcomes for patients.	



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low level)*	4	2	8
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Board assurance provided at all levels of MHLD governance framework – local, divisional and directors, MHLD presents weekly at Corporate complaints and concerns meeting, monthly at QSG, bi monthly to QSE, Board as required/requested and F&P. 2. More focussed monitoring on progress at Board level agreed and implemented. 3. Achieved and implemented renewed focus and escalation arrangements for dealing with operational issues: weekly operations meeting in each area, daily safety huddles, weekly leadership review, MHLD QSG and MHLD F&P. 4. Governance Framework developed and fully embedded – review of committee names being undertaken to ensure consistency with BCUHB framework. 5. Recommendations from Internal Audit Review (2019) implemented. 6. Mental Health Strategy approved by the Board and now in implementation phase with areas sustaining strategy change and new developments evidenced with new initiatives that are being modelled across MH services as good practice.	1. Board and WG oversight as part of Special Measures. 2. External reviews and investigations commissioned (Ockenden and HASCAS). 3. HIW Reviews. 4. Internal objective accreditation. 5. External Accreditation. 6. Delivery Unit oversight of CTP. 7. Caniad coproduction and objective day to day review of services. 8. Enhanced WG support has now concluded following intense scrutiny and

7. Senior Management and Clinical Leadership is no longer a holding structure but implemented with a permanent structure of leadership established, including to Tier 5 & 6. 8. External reviews and visits including positive HIW inspections detailed to QSE and Board. 9. MHLD provides Quality and Performance assurance to Executive accountability meetings in two forms of scrutiny i) Divisional presentation and ii) with each area health economy and is not in escalation as a result of current progress. 10. Monitoring continues via SMIF. 11. Implementation of HASCAS investigation and wider governance review including completion of HASCAS recommendation specific to MHLD has been successfully achieved. This is monitored through corporate governance processes and QSE Committee. 12. Ward accreditation embedded. 13. Improved scrutiny at local and divisional level in relation to PTR has resulted in improved KPIs across all of PTR. MHLD is the only division to have 0 complaints overdue. This is monitored via QSEEL. 14. Implementation of Listening Leads and BE PROUD OD Programme across the division with full engagement at Director level.	input due to assurances provided by MHLD, including PAC report as submitted evidence.

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3 4 5 6 7	PR1	Mental Health

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**Expected Completion date**	**State how action will support risk mitigation and reduce score**	**RAG Status**

Actions being implemented to achieve target risk score	12523	Review of Tier 7 & 8 in leadership structure underway.	Hilary Owen, Head of Governance and Compliance MH&LD	23/12/2020	23/12/2020	In order to support our Phase 2 COVID-19 Recovery plan but also to support the wider implementation of our strategy and direction to pathways way of working, we will review our Leadership and Management Structure. A draft proposal paper has been completed for consideration with a view of undertaking the review during July 2020 – December 2020 undertaking a full OCP process with an ambitious full implementation for a revised Structure in January 2021.	
	12524	Improve the use of patient experience and real time feedback intelligence to inform service improvements.	Hilary Owen, Head of Governance and Compliance MH&LD	23/12/2020	23/12/2020	Capturing Patient experience and Stories are key component of our learning culture going forward. Service User involvement and coproduction are key components of our strategy implementation with representation from Service Users on all change programmes. CANIAD Big Chats are regularly attended by staff from across the Division to test out thinking in relation to service change and to capture learning and lessons learned from Patient experiences.	
	12525	Further embed learning culture	Hilary Owen,	15/12/2020	15/12/2020	Division wide learning events have been undertaken and prior to	

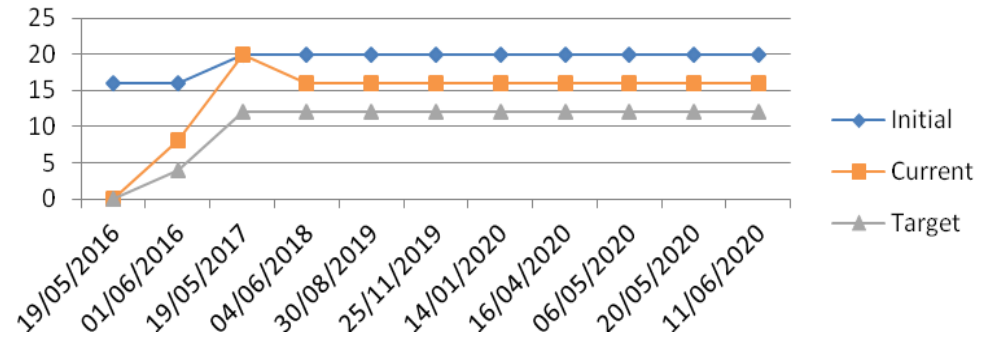
		across the division.	Head of Governance and Compliance MH&LD			COVID were planned to take place on a bi-annual basis. The Learning events have focussed on patient stories, themes and trends and the dissemination of learning from outside of the organisation. Regular learning bulletins are distributed across the division that highlight key learning from SUI's, complaints and concerns and any internal audit or investigations.	
	12526	Systematic implementation of Quality Improvement Methodology across the division at all levels.	Hilary Owen, Head of Governance and Compliance MH&LD	23/12/2020	23/12/2020	To support services and to ensure consistency of approach, we will be delivering a Division wide Quality Improvement (QI) programme of training and support. We have identified legacy funding to support this programme of work. The 12-month training plan, which will be delivered across the whole Division across all levels will commence in July 2020 and will allow individuals and teams to have a greater understanding in quality Improvement methodology allowing for the implementation of local quality improvement projects. Our ambition is to achieve wide scale knowledge of QI, create a culture of continuous learning and	

						improvement whilst delivering our ambitious T4MH Strategy. We have worked with Elliot Blanchard our delivery partners to ensure different methods of training during the COVID Pandemic to include on-line webinar and training materials. All Change programmes will benefit from QI expert advice to ensure consistency in approach.	
	12527	Implementation of actions following skill mix review on inpatients wards to inform our future staffing levels linked to the All Wales Staffing Principles.	Hilary Owen, Head of Governance and Compliance MH&LD	15/12/2020	15/12/2020	MHLD Division continues to engage with the All Wales Inpatient Nursing Assessment. COVID conditions have changed ward configuration and demand and this will be reflected in the next exercise	
	12528	Delivery Unit have undertaken demand and capacity review with the Community Mental Health Teams, which will inform BCUHB and Local Authority future plans for staffing.	Hilary Owen, Head of Governance and Compliance MH&LD	15/12/2020	15/12/2020	We have a fully costed business case for the development of an enhanced Primary Care Offer that will see the embedding of Mental Health Practitioners at a cluster level. Together with Community Navigators and the ICAN offer of community support we envisage that this programme of work with address long standing demand and capacity issues within Primary Care	

						and Community Services. We will commence recruitment into these post in July 2020 with full implementation of the Programme by January 2021.	
	12529	Additional actions to address Sickness across MHLD includes the development of Wellness strategy developed for MHLD – wellness, work and you!	Hilary Owen, Head of Governance and Compliance MH&LD	23/12/2020	23/12/2020	The Wellness, Work and Us Strategy is a 3-year plan and has been developed to ensure that Workforce health and Wellbeing is efficiently, integrated into the Division. Outlining how we intend to promote health and wellbeing for all, with a range of initiatives aligned to 13 key outcomes, to support staff, promote wellness and maximise attendance in Work.	

CRR16	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 19 May 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 11 June 2020
	Risk: A Failure To Discharge Statutory and Legislative Safeguarding Responsibilties	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 19 November 2020

There is a risk that the Health Board does 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] recognising the activities of the Managing Authority and Supervisory Body. This may be caused by a failure to develop and implement suitable and sufficient safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity. This could impact on those persons at risk of harm to whom BCUHB has a duty of care with particular reference to the added challenges due to the National guidance by Welsh Government relating to COVID 19. The impact of redeployment for HV/SN/Midwifery Staff and those within key departments may result in the reduction of engagement with vulnerable people and therefore the identification of those at risk of harm.



	Impact	Likelihood	Score
Initial Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score (Risk Appetite – *low, level)*	4	3	12
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1.BCUHB Safeguarding People at Risk of Harm Reporting Data and Position During COVID 19 and Action Log was presented at COVID 19 QSG on 07.05.20. 2. A cycle of Business Planning meetings have been implemented within the Nursing and Midwifery Directorate which scrutinises and reviews Level 1 and 2 Risks and is attended by the Associate Director of Safeguarding [currently stepped down]. 3. A refreshed Safeguarding Reporting Framework has been implemented which sets out clear lines of accountability and is underpinned by the Cycle of Business.	1. Strengthened Governance and Reporting arrangements. 2. Enhanced engagement with partner agencies. 3. Safe and effective data collection and triangulation of organisational data to identify risk.

4. 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. 5.Risk Management has been embedded into the processes of the Reporting Framework by being included as a standing item on the Safeguarding Governance and Performance and Safeguarding Forum[s] Agendas. Issues of Significance reports require risks to be identified and reported on in terms of mitigating action. 6. The new Senior Management tier has been appointed to within the Safeguarding Structure. This will strengthen strategic oversight in key areas. 7. A paper has been presented to QSG on the 10.1.20, in line with HASCAS / DO recommendation Numbers 8 and 6 and 11 and 9. This is relating to the review and effectiveness of the Safeguarding structure and progress report relating to the DoLS 2017-2018 action plan. 8. Bespoke training continues to be delivered to key high priority areas with responsibilities for 16/17 yr olds who may be / or experience a deprivation of their liberty as a result of a Supreme Court Judgement 26.9.19. 9.Implementation of all identified recommendations with the exception of the BIA vacancy as identified within the Corporate Safeguarding Governance Audit and Deprivation of Liberty Safeguarding [DoLS] Audit, conducted by the NHS Wales Shared Services Partnership Audit and Assurance Service. 10. BCUHB Safeguarding People at Risk of Harm Reporting Data and Position During COVID 19 and Action Log was shared at NWSCB on the 13.5.20 NWSAB on the 14.5.20. 11. Meeting held with Local Authority Directors to discuss their Safeguarding report data and activity with recognition that Area Directors of Nursing are realigning redeployed staff back into HV / SN positions. This will increase face to face contact.	4. Improved compliance against recognised omissions relating to the review and development of Safeguarding policies and Training materials. 5. Regional Safeguarding Boards.

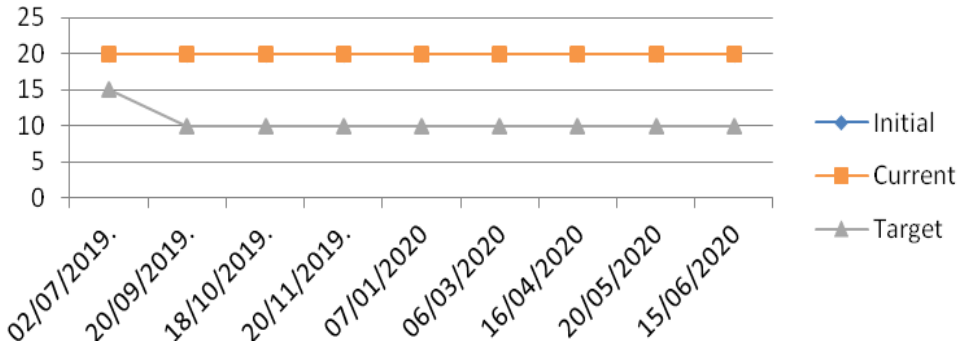
Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
3 7	PR9	Governance

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	Completion date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12463	The revised phase of the review of all Safeguarding JDs will be submitted to A4C July 2020.	Michelle Denwood, Associate Director Safeguarding	31/07/2020	31/07/2020		
	12464	Vacant posts continue to be progressed through the establishment control approval process to maintain a fully funded Safeguarding Team.	Michelle Denwood, Associate Director Safeguarding	12/11/2020	12/11/2020		
	12466	Further structural activity is planned to ensure business continuity and stability within the Corporate Safeguarding Team. This includes the provision of a 7 day on call, flexible working service. This was incorporated into the Structure Report at QSG 10	Michelle Denwood, Associate Director Safeguarding	10/01/2020	05/06/2020	Action completed.	
	12467	In line with the HASCAS Recommendation / DO Recommendation 8, 6, 11 and 9. A Business Case is to be presented to the Finance and performance Group.	Michelle Denwood, Associate Director Safeguarding	13/11/2020	13/11/2020	F&P currently stepped down due to Covid-19	

	12468	The Deprivation of Liberty Safeguarding [DoLS] Audit, conducted by the NHS Wales Shared Services Partnership Audit and Assurance Service, identified an number of recommendations, the outstanding action is the full implementation of the BIA structure and this activity will be in included in the report to Finance and Performance Group	Michelle Denwood, Associate Director Safeguarding	10/11/2020	10/11/2020		
	12469	When the Finance and Performance Group is re-established the Safeguarding and DoLS Business Case will be presented to enable actions Number 4 and 5 to gain approval and implementation.	Michelle Denwood, Associate Director Safeguarding	13/11/2020	13/11/2020		

CRR20	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 2 July 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 June 2020
	Risk: Security Risk	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 1 November 2020

There is a risk the Health Board fails to ensure that a suitable systems are in place to protect staff, patients and stakeholders from security, violence and aggression incidents arising out of our work activity. 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.



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

Controls in place	**Assurances**
1) There is a system in place for a contractor (Samsun) to manage the physical/people aspects of Security for the organisation. 2) A V&A Case manager is in place to support individuals who have been exposed to violence and aggression incidents. 3) An external contractor is supporting the Head of H&S to review all aspects of Security across the Board. 4) An external Police Support Officer is in place part time to support the organisation and staff.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. QSE.

Links to

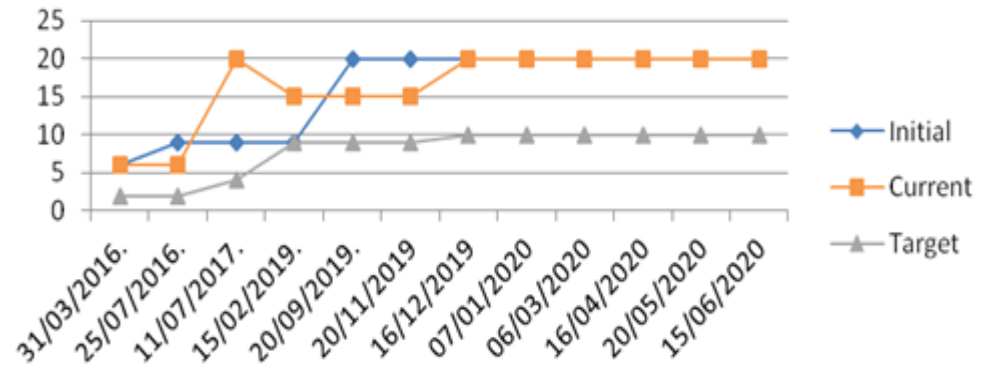
Strategic Goals	Principal Risks	Special Measures Theme
3		SM4 SM1

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	Completion date	State how action will support risk mitigation and reduce score	RAG Status
	12219	A systematic approach is required to both physical and people aspects of the risks identified. This includes: A complete review of CCTV and recording systems.	Mr Peter John Joseph Bohan, Associate Director H & S Equality	31/10/2020	31/10/2020		
	12220	Finalise and implement the CCTV Policy.	Mr Peter John Joseph Bohan, Associate Director H & S Equality	30/10/2020	30/10/2020		
	12221	Clear lines of communication with the contractor, review of the contract in relation to key holding responsibilities and reporting on activities to be implemented.	Mr Peter John Joseph Bohan, Associate Director H & S Equality	30/10/2020	30/10/2020		
	12222	Responsibilities of Security roles within BCUHB to be clearly defined.	Mr Peter John Joseph Bohan,	30/09/2020	30/09/2020		

			Associate Director H & S Equality				
	12223	Lone worker procedures and risk assessments further established	Mr Peter John Joseph Bohan, Associate Director H & S Equality	30/10/2020	30/10/2020		
	12224	Reducing numbers of violence incidents to staff through clear markers and systems for monitoring violent patients.	Mr Peter John Joseph Bohan, Associate Director H & S Equality	30/10/2020	30/10/2020		
	12225	Comprehensive review of Security on gaps in system which was provided to the Strategic OHS group.	Mr Peter John Joseph Bohan, Associate Director H & S Equality	30/10/2020	30/10/2020		

CRR21	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 31 March 2016
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 June 2020
	Risk: Health & Safety Leadership and Management	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 1 November 2020

There is a risk that the Health Board fails to achieve compliance with Health and Safety Legislation. This is due to insufficient leadership and general management. This may result in a negative impact on patient and staff safety, including organisational reputation and prosecution.



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

Controls in place	**Assurances**
1. Health and Safety risk assessment systems are in place in some service areas to protect staff, patients and others from hazards. 2. Health and Safety Management arrangements further developed. 3. Strategic Health and Safety Group in place meeting regularly (3 times in 3 months). 4. Risk Assessments and safe systems of work in place. 5. Mandatory Training in place. 6. Clinical and Corporate Health and Safety Teams established. 7. Corporate Health and Safety Team established. 8. Programme of Annual Self-Assessment Audits. 9. Gap analysis in place. 10. Health and Safety Walkabouts. 11. Health and Safety Report to QSE and Board.	1. Health and Safety Leads Group. 2. The Strategic Occupational Health and Safety Group. 3. QSE.

12. Health and Safety Improvement Project Plan. 13. Action plan developed based on non compliance with legislation. 14. 12-Month action plan developed and 3 year strategy, that is owned by Divisions and Senior Leaders.	

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3		SM4 SM1

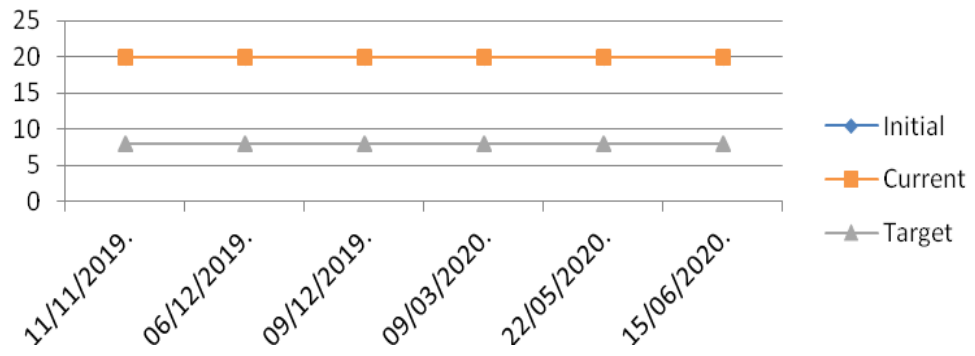
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**Completion date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	167	Ensure monitoring mechanisms are in place to progress the implementation of the H&S Plan.	Phil Townson, Head of Health and Safety	04/06/2019	30/04/2020	Corporate H&S Managers in post CPG/CSF H&S Lead Officers identified	
	12207	Undertaken gap analysis of 31 pieces of legislation. Completed within specified time frame (117 inspections in 7 weeks).	Mrs Susan Morgan, Health and Safety Adviser.	30/10/2020	30/10/2020		
	12208	Develop a programme of intervention and training	Mrs Susan Morgan,	30/10/2020	30/10/2020		

		through TNA Review.	Health and Safety Adviser.				
	12209	Identified RIDDOR reports and scrutiny of process, looking at improved RCA system.	Mrs Susan Morgan, Health and Safety Adviser.	30/09/2020	30/09/2020		
	12210	Review Divisional governance arrangements so that they marry with H&S governance system and reporting to Strategic OHS Group.	Mrs Susan Morgan, Health and Safety Adviser.	30/09/2020	30/09/2020		
	12237	Action plan developed based on non compliance with legislation.	Mrs Susan Morgan, Health and Safety Adviser.	12/06/2020	12/06/2020	The action plan was completed in 2019 and will be updated with new timescales due to delays following team capacity during the COVID period.	
	12238	Monthly action plan developed and 3 year strategy, that is owned by Divisions and Senior Leaders.	Mrs Susan Morgan, Health and Safety Adviser.	30/10/2020	30/10/2020	Strategy and Policy completed – Divisions need to establish own action plans	

	12239	Further develop individual risk register for items of non-compliance identified through gap analysis 8-10 specific items.	Mrs Susan Morgan, Health and Safety Adviser.	20/05/2020	23/05/2020	This action has been completed.	
	12240	Implement findings of internal audit review of process of inspection and governance.	Mrs Susan Morgan, Health and Safety Adviser.	30/09/2020	30/09/2020		

CRR22	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 11 November 2019
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 June 2020
	Risk: Potential to compromise patient safety due to large backlog and lack of follow-up capacity.	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 31 December 2020

The is a risk that patient safety and experience may be comprised due to the Health Board's lack of follow-up capacity especially in outpatients specialities within Secondary across all three sites. This could lead to claims, poor patient experience, harm, reputational damage and deterioration in patient conditions who might have missed their 100% follow-up target.



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

Controls in place	**Assurances**
1. Ophthalmology and Cancer services have been validated and patients who might have come to harm due to missing their follow-up have been prioritised and seen in clinics. 2. Monitoring of follow-up numbers at weekly meetings. 3. External validation team are validating the over 100% missed target date. 4. Close links with all services to ensure appropriate care planning for patients are in place. 5. Strong clinical engagement and project management support established. 6. Prioritisation of patients at clinical risk and harm reviews being undertaken for all patients who have missed their 100% follow-up.	1. Monitoring and governance arrangements for this risk in place. 2. Review of Ophthalmology and Cancer patients now completed. 3. Risk is now regularly reviewed at QSE.

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**

2 3 4 5 7	NA	Strategic and Service Planning

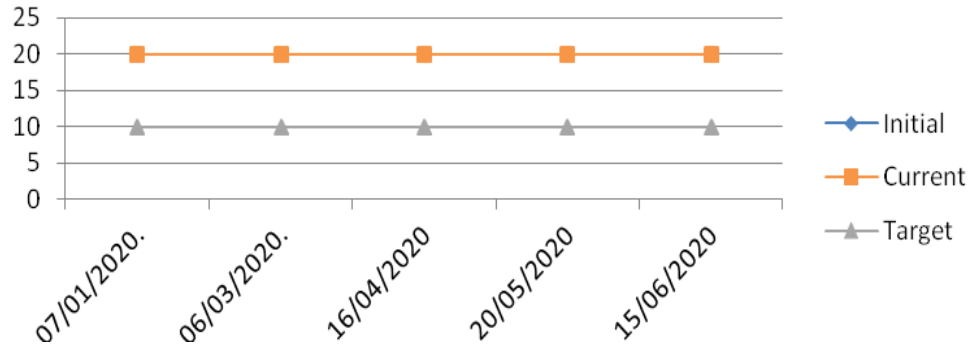
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	Completion date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12406	Backlog patients who have exceeded their follow up time	Mr Andrew Kent, Planned care Lead	31/07/2020	31/07/2020	The SOS handbook is being implemented in late May, in a number of specialties, it will take 6 months before they can be removed from the waiting list	
	12408	implementation of harm reviews	Mr Andrew Kent, Planned care Lead	31/07/2020	31/07/2020	Harm reviews are being undertaken however there is not transparency on how and where it is being reported	
	12409	Work on the trajectory of 15% reduction of the backlog	Mr Andrew Kent, Planned care Lead	31/07/2020	31/07/2020	All follow up appointments that were routine have been paused due to covid-19 pandemic, until routine activity is commenced this	

						target is unachievable	
	12411	Establish a process that will allow the Health Board to contact all patients who are over 52 weeks	Mr Andrew Kent, Planned care Lead	31/07/2020	31/07/2020	This is being covered with the SOS follow up programme	
	12412	Review any new patient breaching 52 weeks	Mr Andrew Kent, Planned care Lead	31/07/2020	31/07/2020	Harm reviews are being undertaken however there is not transparency on how and where it is being reported	
	12413	Agree monitoring and governance arrangements.	Mr Andrew Kent, Planned care Lead	31/07/2020	31/07/2020	The OPD transformation group have been tasked to review the governance framework around the OPD activity	
	12414	Resourcing a sustained in-house validation team	Mr Andrew Kent, Planned care Lead	31/07/2020	31/07/2020	An OPD strategy is being written, part of this is a review of the validation process	

CRR23	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020

	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 June 2020
	Risk: Asbestos Management and Control	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 2 November 2020

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



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

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

7. Air monitoring undertaken in some premises where there is limited clarity on asbestos condition.	

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3		SM4 SM1

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**Completion date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	12241	Undertaking a re-survey of 10-15 premises to determine if the original Asbestos surveys are valid. This is problematic as finances are not available for this work, increasing the risk of exposure to staff and contractors.	Mr Rod Taylor, Director of Estates & Facilities	31/10/2020	31/10/2020		
	12242	Update and review the Asbestos Policy and Management Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/10/2020	31/10/2020		
	12243	Review schematic drawings and process to be implemented to update	Mr Rod Taylor,	31/10/2020	31/10/2020		

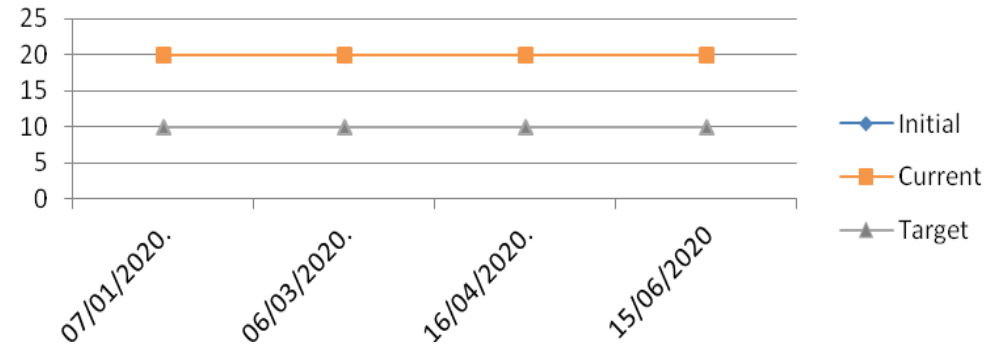
		plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Director of Estates & Facilities				
	12244	Ensure priority assessments are undertaken and highest risk escalated.	Mr Rod Taylor, Director of Estates & Facilities	29/08/2020	29/08/2020		
	12245	Evaluate how contractors are provided with information and instruction on asbestos within their work environment. Ensure work is monitored.	Mr Rod Taylor, Director of Estates & Facilities	29/08/2020	29/08/2020		
	12246	Ensure all asbestos surveys are available at all sites and there is a lead allocated for premises.	Mr Rod Taylor, Director of Estates & Facilities	31/10/2020	31/10/2020		
	12247	Annual asbestos surveys to be tracked and monitor for actions providing positive assurance of actions taken to mitigate risks.	Mr Rod Taylor, Director of Estates & Facilities	31/10/2020	31/10/2020		
	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mrs Susan Morgan, Health and Safety Adviser	31/10/2020	31/10/2020		
	12249	QR Code identification to be provided on all areas of work with identified	Mr Rod Taylor,	31/10/2020	31/10/2020		

		asbestos signage in non public areas.	Director of Estates & Facilities				
	12250	Lack of completed asbestos registers on all sites picked up in H&S Gap Analysis Action Plan.	Mrs Susan Morgan, Health and Safety Adviser	31/10/2020	31/10/2020		

CRR24	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 June 2020

	Risk: Contractor Management and Control	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 1 December 2020

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



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

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

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3		SM4 SM1

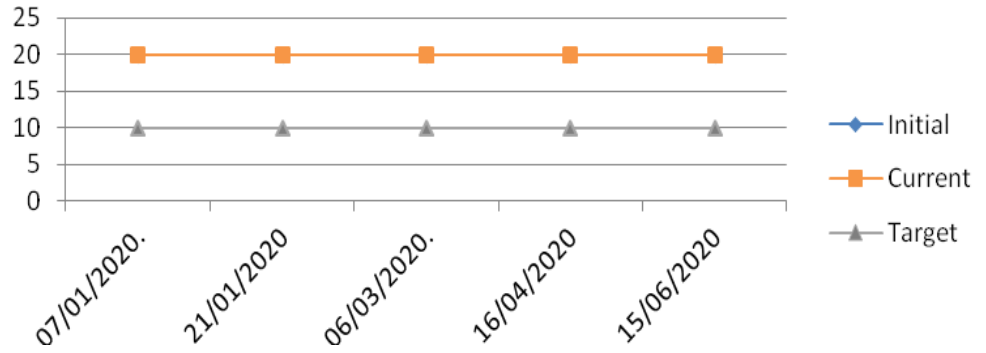
Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	Completion date	State how action will support risk mitigation and reduce score	RAG Status
	12251	Identify current guidance documents and ensure they are fit for purpose.	Mrs Susan Morgan, Health and Safety Adviser	30/11/2020	30/11/2020		
	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mrs Susan Morgan, Health and Safety Adviser	30/11/2020	30/11/2020		
	12253	Draft and implement a Control of Contractors Policy that all adhere to including IT and other services who work on BCUHB premises.	Mr Rod Taylor, Director of Estates & Facilities	30/10/2020	30/10/2020		
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming to site.	Mr Rod Taylor, Director of Estates & Facilities	30/10/2020	30/10/2020		

	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc. Is the current system fit for purpose and robust?	Mrs Susan Morgan, Health and Safety Adviser	30/11/2020	30/11/2020		
	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	30/11/2020	30/11/2020		
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	31/10/2020	31/10/2020		
	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	30/10/2020	30/10/2020		
	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	30/09/2020	30/09/2020		

	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mrs Susan Morgan, Health and Safety Adviser	30/11/2020	30/11/2020		
	12552	Induction process to be completed by all contractors who have not yet already undertaken the induction	Mrs Susan Morgan, Health and Safety Adviser	30/11/2020	30/11/2020		
	12553	Evaluation of standing orders and assessment under Construction Design and Management Regulations.	Mrs Susan Morgan, Health and Safety Adviser	31/10/2020	31/10/2020		

CRR25	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020

	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 June 2020
	Risk: Legionella Management and Control.	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 30 November 2020
There is a significant risk that the 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 death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.		



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

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

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3		SM4 SM1

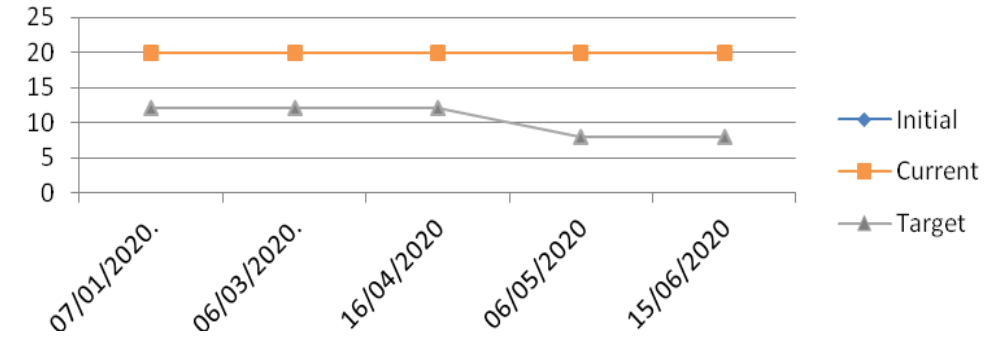
Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	Completion date	State how action will support risk mitigation and reduce score	RAG Status
	12261	Update Corporate H&S Review template and H&S Self-Assessment Template to ensure that actions are completed by all wards and Departments to ensure systems are in place.	Mrs Susan Morgan, Health and Safety Adviser	30/11/2020	30/11/2020		
	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	27/11/2020	27/11/2020		
	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	27/11/2020	27/11/2020		

	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	30/08/2020	30/08/2020		
	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	30/08/2020	30/08/2020		
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	27/11/2020	27/11/2020		
	12267	Awareness and training programme in place to ensure all staff aware? Departmental Induction Checklist.	Mrs Susan Morgan, Health and Safety Adviser	27/11/2020	27/11/2020	Date was amended by PB (Associate Director) due to delays to this program with the COVID -19 impact on the workload of the H&S team and other teams	

						that are needed to support this action being completed	
	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	30/09/2020	30/09/2020		
	12269	Water Safety Group provides assurance that the Policy is being effectively implemented across all sites, this requires appropriate clinical and microbiology support to be effective	Mr Rod Taylor, Director of Estates & Facilities	31/10/2020	31/10/2020		
	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.	Mrs Susan Morgan, Health and Safety Adviser	27/11/2020	27/11/2020		

CRR26	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 7 January 2020

	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 June 2020
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 1 November 2020
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, lack of relevant operational Risks Assessments. This may lead to major Fire, breach in Legislation and ultimately prosecution against BCUHB.		



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

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

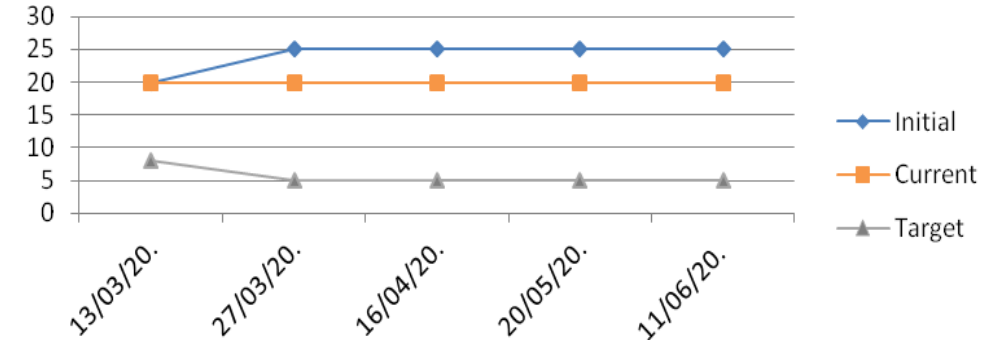
Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3		SM4 SM1

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	Completion 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	30/10/2020	30/10/2020		
	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates & Facilities	30/10/2020	30/10/2020		
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates & Facilities	30/10/2020	30/10/2020		
	12276	Consider how bariatric evacuation training - is undertaken define current plans for evacuation and how this is achieved?	Mr Rod Taylor, Director of Estates & Facilities	30/10/2020	30/10/2020		
	12279	AlbaMat training - is required in all service areas a specific training package is required with	Mr Rod Taylor, Director of	29/01/2020	29/01/2020		

		Fire and Manual Handling Team involved.	Estates & Facilities				
	12554	Commission independent shared services audits.	Susan Morgan - Health & Safety Adviser	30/10/2020	30/10/2020		
	12555	Information from unwanted fire alarms and actual fires is collated and reviewed as part of the fire risk assessment process.	Susan Morgan - Health & Safety Adviser	30/10/2020	30/10/2020		
	12556	The Fire Authority Regularly inspect BCUHB premises and provide reports on their findings which have action plans in place.	Susan Morgan - Health & Safety Adviser	30/10/2020	30/10/2020		
	12280	Ensure actions from the fire authority findings are escalated and actions completed reporting back to the Strategic OHS Group.	Mr Rod Taylor, Director of Estates & Facilities	20/05/2020	20/05/2020	This action is completed	

	Assuring Committee: Quality, Safety and Experience Committee Strategy, Partnership and Population Health Committee	**Date Last Reviewed:** 11 June 2020
	Risk: Risk to public health and safety arising from an outbreak of COVID-19 and demand outstripping organisational capacity	**Date of Committee Review:** 5 May 2020 **Target Risk Date:** 31 December 2020

There is a risk to public health and safety from an outbreak of coronavirus (COVID-19) and this may impact on the ability of the Health Board to respond to this, arising from increased unscheduled demand on healthcare resources (including specialist resources and equipment) and a reduction in available resource to meet that demand such as workforce shortages arising from staff who are unwell or self-isolating.



	Impact	Likelihood	Score
Initial Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score (Risk Appetite – *low level)*	5	1	5
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. Gold Commander in place, COVID Cabinet in place, Health Emergency Control Centre (HECC) activated 7 days per week led by HECC Commander (executive level) and supported by local control centres – set out through a command and control framework. 2. Specialist work streams in place reporting to HECC Commnder including clinical pathways group and clinical advisory group. 3. Emergency plans and business continuity plans. 4. Opertional modelling undertakena and information and planning cells in place. 5. Access to specialist public health, clinical, operational and governance advice.	1. Command and control structures (see COVID-19 Command Structure Framework)

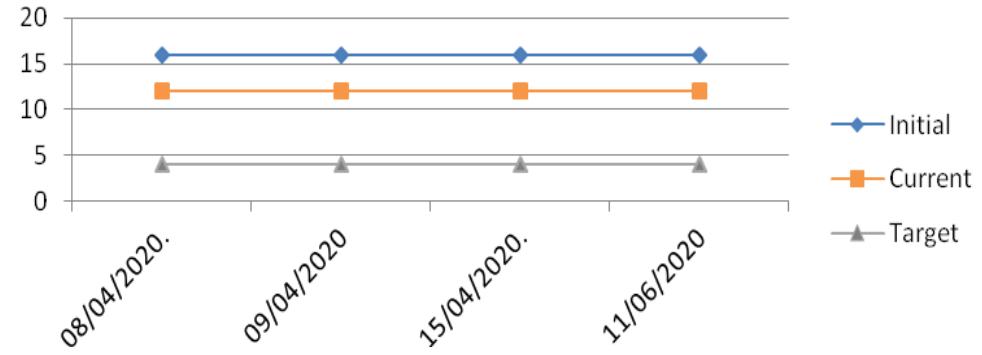
6. Coordinated communication links with Welsh Government and Public Health Wales. 7. Public health messages including on social media and posters in hospitals. 8. Infection control measures in line with national guidance. 9. National guidance reviewed and cascaded - daily staff bulletin. 10. Advice for staff issued by Workforce and Organisational Development. 11. Self isolation measures for staff in line with national guidance. 12. Agreement to utilise temporary staffing off framework. 13. Additional staffing through retired staff returning and volunteers. 14. Patient and key worker testing in line with national guidelines. 15. Revised incident reporting process in place for staff affected by COVID. 16. Community testing units in place. 17. Non-essential activities stood-down i.e. corporate meetings. 18. Linked into national essential services cell to ensure patient access to critical services. 19. Cancelling clinically appropriate non-urgent and elective activity. 20. Development of additional capacity and field hospitals. 21. Public donations being coordinated through Awyr Las and checked for infection control and health and safety standards. 22. Multi agency co-ordination through SCG and TCG and Military Liaison Officer. 23. Establishment of daily PPE Taskforce led by Executive Director of Nursing and Midwifery/Deputy CEO. 24. Staff wellbeing support through BCU Staff Wellbeing & Support Service and national Health for Health Professionals Wales (HHPW).	

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3 4 5 6 7	PR7 PR1 PR3 PR8 PR4	Not Applicable

Risk	**Action**	**Action**	**Action Lead/**	**Due**	**Expected**	**State how action**	**RAG**

Response Plan	ID		Owner	date	Completion date	will support risk mitigation and reduce score	Status
Actions being implemented to achieve target risk score	12288	Ongoing real time management via Health Emergency Control Centre (HECC), local control centres and work streams - each work stream has a PRAID log to track and manage actions.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	ongoing action	ongoing action	This is an open, ongoing action for the duration of the emergency.	

	Assuring Committee: Quality,Safety and Experience Committee Quality and Safety Group	**Date Last Reviewed:** 11 June 2020
	Risk: Risk of infection from COVID-19 to staff and patients as a result of inadequate supply, quality or usage of PPE	**Date of Committee Review:** 5 May 2020 **Target Risk Date:** 31 December 2020
There is a risk to patients and staff arising from the shortage of PPE supply (as a result of increased demand globally) and the quality of PPE being less than needed (as a result of utilising alternative supply chains and manufacturers). It is also recognised that staff have anxieties about these issues and this may impact on their wellbeing, confidence and resilience.		



	Impact	Likelihood	Score
Initial Risk Rating	4	4	16
Current Risk Rating	4	3	12
Target Risk Score (Risk Appetite – *low level)*	4	1	4
Movement in Current Risk Rating Since last presented to the Board in April 2020	*unchanged*		

Controls in place	**Assurances**
1. PPE Steering Group led by Executive Director of Nursing and Midwifery including trade union representative. 2. Daily PPE Stock Report to HECC Silver and Gold Command. 3. PPE guidance to staff issued in line with national guidance from Public Health Wales. 4. PPE guidance detailed in daily staff COVID bulletin and specific PPE COVID intranet page - communications team part of PPE Steering Group. 4. Expert advice to senior leaders and clinical leaders available from infection control team. 5. Dedicated PPE email account for staff queries and concerns.	1. Command and control structures (see COVID-19 Command Structure Framework). 2. PPE Taskforce (daily meeting led by Executive Director of Nursing and Midwifery / Deputy CEO).

6. Face fit testing programme in place. 7. Donations of PPE received via Awyr Las and checked against infection control and health and safety standards. 8. Daily PPE assurance checklist for matrons - reported through informatics dashboard. 9. Modelling in place to assess PPE demand against available stock, linked to national modelling by Welsh Government. 10. Visible clinical leadership and PPE champions in place. 11. Incident reporting and investigation process in place.	3. Daily PPE Stock Report to HECC Silver and Gold Command. 4. Regular review of risk by PPE Taskforce and governance meetings.

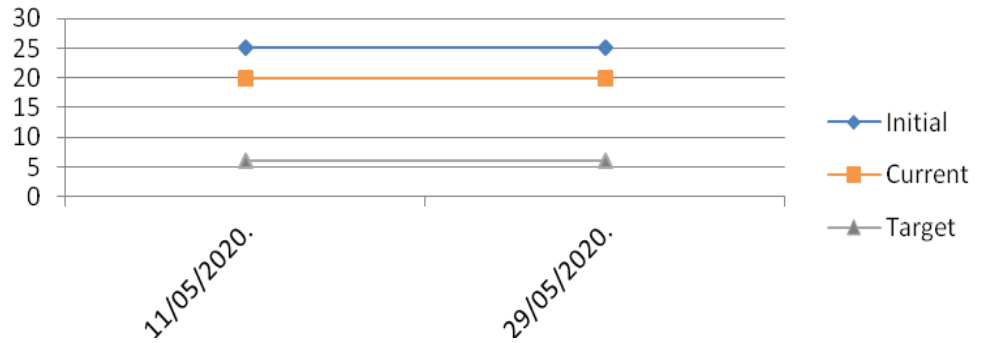
Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
3 5 6	PR9 PR1 PR4	Not Applicable

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**Completion date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	12427	Services to identify and promote PPE ambassadors and be provided with tabards.	Mr Matthew Joyes, Assistant Director of Patient Safety & Experience	30/06/2020	11/06/2020	Action completed	
	12430	Ongoing monitoring through the PPE Taskforce and response to issued raised promptly and effectively.	Mr Matthew Joyes, Assistant Director of	Ongoing action	Ongoing action	Ongoing	

			Patient Safety & Experience				

Appendix 2: Details of new risk for consideration and inclusion onto the CRR.

CRR29	**Director Lead:** Executive Director of Public Health	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 29 May 2020
	Risk: Timely access to care homes	**Date of Committee Review:** 5 May 2020
		Target Risk Date: 31 December 2020
There is a risk that there will be a delay in residents accessing placements in care homes and other communal facilities. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on wider capacity and patient flow.		



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

Controls in place	**Assurances**
1. Multi-agency care home cell established as part of the emergency planning arrangements. 2. PPE distribution system operational including identification and support for residents with aerosol generating procedures. 3. Testing for residents and staff in place aligned with national guidance.	1) Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW).

4. Unified “One contact a day“ data gathering from care homes established with 6 Local Authorities. 5. Systems for Access to specialist advice via Public Health Wales and the Environmental Health Teams in place to manage isolation and outbreaks. 6. Personalised care and support plans promoted led by specialist palliative care team. 7. New arrangements in place for the timely provision of pharmacy and medication support at the end of life. 8. Remote consulting offered by general practice. 9. Home first bureaus established by the 3 area teams to facilitate sensitive and collaborative decision making on hospital discharge, transfer between care homes and admissions from home. 10. Regular communication with care homes at a local level and across BCU.	2) Oversight via Gold and Silver Strategic Emergency Planning. 3) Oversight as part of the Local Resilience Forum via SCG

Links to		
Strategic Goals	**Principal Risks**	**Special Measures Theme**
1 2 3 4		Not Applicable

Risk Response Plan Actions being implemented to achieve target risk score	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**Completion date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
	12431	Establish separate discharge cell to ensure system wide leadership and action to implement the revised step up step down hospital discharge requirements. .	Mrs Ffion Johnstone, Area Director (West)	20/05/2020	20/05/2020	Action completed	

	12433	Develop a BCU wide approach to primary care support and intervention, including GPOOH	Liz Bowen, Area Medical Director	30/06/2020	30/06/2020		
	12434	Develop electronic daily reporting metrics that are robust analysed at an organisational level	Mrs Grace Lewis-Parry, Assistant Director primary and community services	30/06/2020	05/06/2020	Daily reporting now in place across all 6 Local authority areas. Analysis then triggers implementation of the escalation and support plan. Summary data included in care home dashboard.	
	12435	Complete and implement a North Wales care home escalation and support tool that complements national work programmes.	Mrs Andrea Hughes, Area Nurse Director	30/06/2020	03/06/2020	Action completed	
	12436	Ensure that all new national guidance on testing for care home staff and residents is widely communicated and implemented.	Mrs Grace Lewis-Parry, Assistant Director primary and community services	30/06/2020	30/06/2020	Ongoing weekly reviews	
	12437	Continue to refine and develop communication with care homes	Mrs Grace Lewis-Parry,	30/06/2020	30/06/2020	Daily calls made. Twice	

		at a local level and across North Wales.	Assistant Director primary and community services			weekly meetings continue with Care Forum Wales, CIW and partners. Weekly national briefings circulated supplemented by local information.	
	12439	Work with Welsh government and Health Boards across Wales to deliver a revised financial support package for care homes.	Mrs Grace Lewis-Parry, Assistant Director primary and community services	30/06/2020	30/06/2020	A draft proposal is being finalised and is expected to be presented to the Minister for approval week beginning 8.6.20.	

Cyfarfod a dyddiad: **Meeting and date:**	Quality, Safety and Experience Committee 3.7.20
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Summary of business considered in private session to be reported in public
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Gill Harris Deputy Chief Executive / Executive Director Nursing and Midwifery
Awdur yr Adroddiad **Report Author:**	Diane Davies, Corporate Governance Manager
Craffu blaenorol: **Prior Scrutiny:**	None
Atodiadau **Appendices:**	None

Argymhelliad / Recommendation:

The Committee is asked to note the report

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

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

Sefyllfa / Situation:

To report in public session on matters previously considered in private session

Cefndir / Background:

Standing Order 6.5.3 requires the Board to formally report any decisions taken in private session to the next meeting of the Board in public session. This principle is also applied to Committee meetings.

Asesiad / Assessment

The Quality, Safety and Experience Committee considered the following matter in private session on 5.5.20

- Healthcare Inspectorate Wales update report