Bundle Quality, Safety & Experience Committee 5 July 2022

3.5	11:40 - QS22/216 - Quality/Safety Awards and Achievements - Executive Director of Nursing & Midwifery - Consent - Paper

QS22.216 - QSE - July 2022 - Quality Achievements.docx

3.6	11:41 - QS22/217 - YGC Improvement Plan - Deputy CEO/Executive Director of Integrated Clinical Services/Executive Director Transformation, Strategic Planning and Commissioning/Executive Director of Nursing & Midwifery - Assurance - Paper

QS22.217 - 20220705 QSE - YGC Improvement Plan-final.docx

QS22.217b - YGC action plan - QSE - 050722 -F.pdf

QS22.217bYGC action plan - QSE - 050722 -F.pptx

3.7	12:01 - QS22/218 - Urology - Deputy CEO/Executive Director of Integrated Clinical Services - Assurance - Verbal
3.8	12:11 - QS22/219 - Human Tissue Authority Preparedness Report - Executive Medical Director - Assurance - Paper

Item withdrawn

3.9	12:21 - QS22/220 - Vascular Update - Executive Medical Director - Assurance - Paper

QS22.220 - QSE Paper June 22 NR V1.docx

4.0	ANNUAL REPORTS
4.1	12:31 - QS22/221 - Chairs Assurance Reports - Lead Executives - Consent - Paper

QS22.221a - IPSG Committee Chair's Assurance Report for QSE - May and June 22 meetings.docx

QS22.221b - Clinical Effectiveness Group Chairs Assurance Report QSE July 2022 - v1.1.docx

QS22.221c - BCUHB Vascular Quality Review Panel Chair's Assurance Report submitted 15 June for QSE Committee 5 July 2022.docx

QS22.221d - QSE - July 2022 - PCE Group Chair's Report.doc

QS22.221e - QSE - July 2022 - PSQ Group Chair's Report.doc

5	CLOSING BUSINESS
5.1	12:32 - QS22/222 - Issues Discussed in Private Session - Chair - Assurance - Paper
5.2	12:33 - QS22/223 - Date of Next Meeting - Chair - Information - Verbal

6 September 2022

Agenda Quality Safety Experience Committee

Date 05/07/2022
Time 9:30 – 13:30
Location Teams
Chair Lucy Reid

Agenda item	Item	Lead	Action	Paper/Verbal
1.0 OPENING ADMINISTRATION				
1.1	Welcome, introductions and apologies for absence	Chair	information	Verbal report
1.2	Declarations of interest on current agenda	Chair	Decision	Verbal Report
1.3	Minutes of last meeting – 3 May 2022	Chair	Decision	Paper
1.4	Action log	Chair	Decision	Paper
1.5	Patient Story	Executive Director of Nursing & Midwifery	Assurance	Video
1.6	Report of the Lead Executive	Deputy CEO/Executive Director Of Integrated Clinical Services	Information	Paper
2.0 STRATEGY AND POLICY				
2.1	Community Health Council SLT Report	Director Therapy Services, Therapies & Health Science	Consent	Paper
2.2	Discharge SOP	Deputy CEO/Executive Director Of Integrated Clinical Services	Decision	Paper
2.3	Medical Devices Training Policy	Director Therapy Services, Therapies & Health Science	Decision	Paper
3.0 QUALITY SAFETY AND PERFORMANCE				
3.1	Mental Health Improvement Plan	Executive Director of Public Health	Assurance	Paper
3.2	Corporate Risk Strategy	Board Secretary	Assurance	Paper

Agenda item	Item	Lead	Action	Paper/Verbal
3.3	Quality & Performance Report	Executive Director of Finance	Assurance	Paper
3.4	Patient Safety Report (to include HIW reports)	Executive Director of Nursing & Midwifery	Assurance	Paper
3.5	Quality/Safety Awards and Achievements	Executive Director of Nursing & Midwifery	Consent	Paper
3.6	YGC Improvement Plan To include: • Vascular Services • Immediate overarching ED Actions • Actions to reduce ED handovers and trajectories	Deputy CEO/Executive Director Of Integrated Clinical Services/ Executive Director Transformation, Strategic Planning, And Commissioning/ Executive Director of Nursing & Midwifery	Assurance	Paper
3.7	Urology	Deputy CEO/Executive Director Of Integrated Clinical Services	Assurance	Verbal
3.8	Human Tissue Authority Preparedness Report	Executive Medical Director	Assurance	Paper
3.9	Vascular Update	Executive Medical Director	Assurance	Paper
4.0 ANNUAL REPORTS				
4.1	Chair's Assurance Reports from Strategic and Tactical Delivery Groups • Patient Safety Quality Group • Strategic Occupational Health and Safety Group • Clinical Effectiveness Group • Patient and Carer Experience Group	Lead Executives	Consent	Paper

Agenda item	Item	Lead	Action	Paper/Verbal
	• Infection Prevention Steering Group • Vascular Quality Panel • Vascular Steering Group			
5.0 CLOSING BUSINESS				
5.1	Issues Discussed in Previous Private Session	Chair	Assurance	Paper
5.2	Date of Next Meeting – 6 September 2022	Chair	Information	Verbal
5.3	Exclusion of Press and Public	Chair	Information	Verbal Report

Agenda item	Item	Lead	Action	Paper/Verbal

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 3 May 2022
Via Teams

Present:
Lucy Reid	Independent Member (Chair)
Jackie Hughes	Independent Member
John Gallanders	Independent Member

In Attendance:
Ramesh Balasundram	Hospital Medical Director (part of the meeting)
Gareth Evans	The Acting Executive Director Of Therapies & Health Science
Sue Green	Executive Director of Workforce and Organisational Development
Gill Harris	Executive Director of Integrated Clinical Delivery/Deputy Chief Executive
Dave Harris	Internal Audit
Matthew Joyes	Acting Associate Director of Quality Assurance
Mandy Jones	Director of Nursing
Fleur Jones	Audit Wales
Joanne Kendrick	Head Of Nursing East, Mental Health & Learning Disabilities
Nick Lyons	Executive Medical Director
Kirsty Lagdon	HIW
Molly Marcu	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Mike Smith	Interim Director Of Nursing Mental Health
Gaynor Thomason	Acting Executive Director for Nursing and Midwifery
Conrad Wareham	Interim Deputy Medical Director
Iain Wilkie	Interim Director of Mental Health

Agenda Item	Action
QS22/75 Patient, Carer or Staff Story **QS22/75.1** The Acting Associate Director of Quality Assurance introduced the story which was shared by a gentleman who is the sole carer for his mother who has severe mixed dementia. The carer explained that his mother was admitted to Ysbyty Glan Clwyd with chest pains and vomiting. The carer explained the issues that his mother and he encountered during her stay including the lack of dementia training or understanding of the Butterfly Scheme and that an important letter explaining her diagnosis and his full time carer responsibilities was lost by the hospital.	

QS22/75.2 The Acting Associate Director of Quality Assurance advised that the Butterfly Scheme was being adopted across the Health Board, that actions had been agreed around patient property and that there was a specific piece of improvement work taking place to ensure that dementia care training is undertaken by all staff. The Committee thanked the carer for sharing his experience.

QS22/75.3 The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive advised that she would ensure that the Butterfly Scheme had been implemented by testing and monitoring. It was noted that there had been a failure on the guidance in place for visiting and that a piece of work is now taking place to check that all wards have the correct visiting policies and that staff understand what they are.

QS22/75.4 An Independent Member highlighted that dementia strategies had been signed up to two years previously and that he was disappointed to hear the experience shared at the meeting. He questioned why the Butterfly Scheme needed to be relaunched and why there was no mention of the third sector support services available. Concern was raised around mandatory training.

QS22/75.5 The Committee noted that work is ongoing with the Transformation Team to ensure that everything being discussed does not return and is embedded and not lost in the system and that the same approach and methodology is used.

QS22/75.6 The Executive Director of Workforce and Organisational Development clarified mandatory training and that Dementia Training is not currently part of level one training and that this may need to be reviewed. She highlighted that it may not be the training that was the problem but the application of the training.

QS22/75.7 The Acting Executive Director for Nursing and Midwifery noted that recognition to the story must be noted and that the author comes across as a caring and kind individual who just wanted to get care for his mother. The powerful message noted was about the number of unpaid carers in the system, the Committee noted the Dementia Hospital Charter being reviewed at a later item in the meeting. The Acting Associate Director of Quality Assurance advised that he would investigate if there were electronic triggers available in the system to highlight if patients are dementia diagnosed when the attend in a hospital setting.

MJ

QS22/75.8 An Independent Member reiterated her disappointment at a story such as this is being heard again at the Committee and that the Dementia Champions needed some support and help around their role as a carer within the organisation. It was noted that it is not just dementia patients who struggle to navigate the system and that sometimes language was a barrier or patients who require additional care but do not have dementia also find it difficult.

QS22/75.9 The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive agreed that wider awareness was required and that a link into Communications to support would be helpful, that one of the things just been revised is the visiting guidance into the Emergency Departments (EDs) which will

be reviewed at the Executive Team meeting the following week, this would allow patients to be accompanied into the ED if they are unwell, of an age or trying to articulate in a language of their choice.	
QS22/75.10 It was noted that all of the stories reviewed are shared back with the service and with managers and that this has been done or is in the process of being done. The theme in many of the stories received is that of compassion and basic communication which leads to patients and carers having a much better experience.	
QS22/75.11 The Committee Chair requested that an update of the dementia strategy implementation to be received at a future meeting. The Acting Executive Director for Nursing and Midwifery agreed that she would invite the Dementia Lead to a future meeting which would also help the Board to be reminded about their own dementia responsibilities.	**GT**
QS22/75.12 It was resolved that the Committee receive and reflected upon the carer story.	
QS22/76 Apologies for Absence	
QS22/76.1 Apologies were received from Cheryl Carlisle, Chris Stockport, Adrian Thomas	
QS22/77 Declarations of Interest	
QS22/77.1 No declarations of interest were raised. It was noted that now Hugh Evans had joined the Health Board and had been invited to be a member of the QSE Committee.	
QS22/78 Minutes of Previous Meeting Held in Public for Accuracy	
QS22/78.1 The Acting Executive Director Of Therapies & Health Science noted that this was the first day attending the meeting in this role and that a change was required in the minutes on Page one to reflect this.	PPJ
QS22/78.2 An Independent Member agreed to send comments to the Head of Corporate Affairs outside of the meeting.	JH
QS22/78.3 With regards to the Action around The Executive Director of Public Health to bring back some information this was in relation to the co-occurring approach rather than 136 and should be amended in the minutes and action log.	PPJ
QS22/78.4 It was resolved that subject to the noted amendments the minutes were approved.	
QS22/79 Matters Arising and Table of Actions	
QS22/79.1 The Committee reviewed the action log and closed actions where appropriate.	

QS22/80 Report of the Chair **QS22/80.1** The Committee received the Chair's Report. **QS22/80.2 It was resolved** that the Committee received the Chair's report.	
QS22/81 Report of the Lead Executive **QS22/81.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive presented her report and it was agreed to invite the Dementia Team back in to triangulate the work that is being taken forward in workshop. It was noted that the Okenden Report would return to a future meeting but issues had been identified that were wider than Maternity. **QS22/81.2** An Independent Member noted that the report highlights a number of Reports where by Improvement Work will Commence or is being planned and that going forward timelines would be helpful. The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive advised that conversations are ongoing with regards to a single improvement approach and that some of the standards within Ysbyty Glan Clwyd (YGC) are being reviewed in the forthcoming week at the Executive Team Meeting. **QS22/81.3 It was resolved** that the Committee received the Lead Executive's report.	
QS22/82 Clinical Audit Plan **QS22/82.1** The Committee noted that the overarching plan was not received and that given that the role of the Committee was to approve and be assured, an extraordinary meeting be convened for this to take place. **QS22/82.2 It was resolved** that an extraordinary meeting should be convened.	PPJ/MM
QS22/83 Psychological Therapies Report **QS22/83.1** The Acting Executive Director Of Therapies & Health Science presented the paper advising that he was proposing three specific actions, these being: • **Action 1**: Map our current position across all adult (physical and mental health) and children's services using the existing Matrics Cymru and Matrics Plant frameworks. Timeline – By September 2022. • **Action 2**: Review the terms of reference for the BCUHB Psychological Therapies Management Committee. Timeline – By July 2022. • **Action 3**: The Psychological Therapies Management Committee will oversee the construction of a plan to develop a framework for psychological informed care with BCUHB. Timeline – By December 2022.	

QS22/83.2 The Committee discussed the actions and felt that ensuring that the patient was at the centre was critical, specifically that children and young people moving through the patient pathway were not lost. The Committee were supportive of the actions with the agreement that the full report was taken off the web page and a link to it remains, this will enable focus going forward to be the patient centred way. It was noted that Report's conclusions/recommendations are of note, but are not universally accepted as valid, and historically it had been sensitive to some people **QS22/83.3** The Chair concluded that discussion had been about the fact that the three actions would enable a re-set, that the demand on the service and the type of therapy has changed that was being reviewed. Given the support for the three actions it was agreed that the link could be taken down, however, following the completion of these three actions a reconciliation between the outcome of these actions against the original report, it should be noted that any reasons behind the changed be clarified. **QS22/83.4** **It was resolved** that the Committee agreed with the above stated three actions to move forward and that the report be removed from the website and replaced with a link and that the triangulation between outcomes be clarified.	**GE**
QS22/84 Dementia Hospital Charter **QS22/84.1** The Committee received the report and it was agreed to ask the Dementia Leads to return to QSE. It was noted that this should also return to a Board Workshop specifically for Board Training **QS22/84.2** The Committee were extremely supportive of the Charter. **QS22/84.3** **It was resolved** to support the requirement for the Board engage in training.	GT/MM
QS22/85 Covid 19 Update **QS22/85.1** It was noted that this item was down for Consent, the Committee approved the six recommendations. It was noted that the step down of Gold required Cabinet approval and that a report would be shared with them. The Committee discussed staff leaving the organisation and it was noted that contingency cover was being implemented. **QS22/85.2** **It was resolved** that the Committee the received and acknowledged the Charter.	GH
QS22/86 Patient Safety Report **QS22/86.1** The Acting Associate Director of Quality Assurance presented the Patient Safety Report and focussed on the overall Serious Incident increase, it was noted that investigations were being monitored within specific timescales with embedded learning coming from the investigations. It was noted that there were	

42 nationally reportable incidents during the two month period monitored and three were classified as never events. The themes of the Serious Incidents were noted as falls, pressure ulcers and deteriorating patients. The details of the Never Events were clarified.

QS22/86.2 The Acting Associate Director of Quality Assurance advised that one open independent investigation would be coming to the next QSE meeting with the primary issues highlighted as communications. It was noted that there were two safety alerts still open and that these would have completed in the next two weeks. It was noted that the challenge was the consistent application across all of the services.

QS22/86.3 The Committee noted that we are seeing inquests listed due to the significant numbers not heard over the Covid period. It is further noted that Regulation 28's had been received with a notice of two weeks.

QS22/86.4 An Independent Member raised concerns that the learning coming out of these events should be standard basic practice the Committee queried basic training and that fundamental care not being implemented.

QS22/86.5 The Acting Executive Director for Nursing and Midwifery agreed with the Committee noting that it was now important to remind people of their professionalism, revisit inductions, check that people understand what they should be doing and that they understand that training is their responsibility and should be available. It was noted that the matron check list had been strengthened.

QS22/86.6 The Executive Director of Workforce and Organisational Development requested that reference to HSE is included in the report both in terms of reporting, triangulation and learning from near misses. The Committee noted the live investigation in to the incident at the Hergest Unit. The Acting Associate Director of Quality Assurance advised that further work was required around near misses, that the new Datix system being implemented would help.

QS22/86.7 The Chair advised that focus needed to be on near misses and risk rather than outcome.

QS22/86.7 An Independent Member referenced overdue reports, them being overdue because background documents were unavailable, he also queried the length of time litigation took and the impact this would have on families being unacceptable. The Acting Associate Director of Quality Assurance agreed with the points raised around overdue reports and clarified the reason why litigation took the length of time it did.

QS22/86.8 The Committee was extremely concerned with the contents of the report, that although there is a lot of action taking place there it was not having the desired impact. It was suggested that future deep dives would be required to triangulate and understand the impact. The Chair thanked the Acting Associate Director of Quality Assurance on the quality of the information contained in the report.

MJ

[Neil Rogers and Neil and Ramesh Balasundram joined the meeting] **QS22/86.9 It was resolved** that the Committee noted the report.	
QS22/87 Quality/Safety Awards and Achievements **QS22/87.1** The Quality/Safety Awards and Achievements paper was received with thanks. **QS22/87.2 It was resolved** that the Committee noted the report.	
QS22/88 Vascular Services **QS22/88.1** The Executive Medical Director presented the paper noting that the CHKS report would return to the Vascular Steering Group but that it would not be received until it was of good quality. The report was commissioned to understand that if by changing to a centralised approach outcomes were unchanged. It was noted that the standing down of the make safes would be an Executive Decision. The Executive Medical Director and the Acting Board Secretary advised that they had met with the Chair of the Vascular Quality Panel and that the Panel will report directly into QSE. **QS22/88.2** The Committee discussed resource it was noted that The Acting Associate Director of Quality Assurance had moved four staff to give support to the Vascular Quality Panel and will be called the Vascular Quality Team and would be picking up the Serious Incidents. **QS22/88.3** An Independent Member asked that given the 28 day make safes in place had cancellation of appointments impacted on delays. The Executive Medical Director advised that there had been scarcely any change to patients due to the 28 day make safes. He agreed to share to the number of Vascular concerns that had been received and what other ways concerns had been received following the help line. **QS22/88.4 It was resolved** that the Committee received the report from the Vascular Steering Group.	 NL
QS22/89 Update on the Urology Transformation Programme **QS22/89.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive gave an update on the Urology Review highlighting that all of the Ombudsman actions were complete and that an improvement group had been set up. It was noted that the Terms of Reference had been agreed and supported and the request for the external Royal College review was being taken forward and improvement plans would be aligned. **QS22/89.2** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive highlighted that the Cancer Improvement Group had been set up and was buddying with the Manchester Cancer Board and that the Chair is an	

urologist. The Network Director is appointed and Network Manager interviews would commence the following week. The Clinical Lead had been signed off and it was going out to advert. The robot had arrived and a training schedule was being developed.

QS22/89.3 It was resolved that the Committee received the Urology Transformation Programme update.

QS22/90 YGC Action Plan

QS22/90.1   The Acute Care Director presented the plan as distributed, it was noted that the HIW Action Plan would likely be signed off by Tuesday 10 May. A query was raised as to who would be taking the actions forward and that many of the actions described were quite broad.

QS22/90.2   The Acute Care Director advised that a lot of site issues related to congestion, manifesting with ambulances being held outside. It was noted that the immediate turnaround plan, highlighted in appendix 4 of the papers, which ran during March, had shown significant results.

QS22/90.3 The Acting Executive Director for Nursing and Midwifery queried how these were going to be embedded given that the issues being raised were not new issues. The Acute Care Director advised that a rhythm of the day is consistently taking place, day in and day out, and that this felt like it was having an impact. Professional Medical Standards within YGC were begin highlighted to employees. The Hospital Medical Director highlighted that the culture within the organisation had been very negative.

QS22/90.4   An Independent Member raised concerns that, if letters and job descriptions, were having to be distributed he was concerned about the workforce being fit for purpose. The Committee noted that it was a specific HIW action to remind staff about their professional responsibility and this had been done.

QS22/90.5 The Executive Medical Director clarified that assurance could not be taken from the plan but that it signalled that there were good things happening but that there was recognition that there were significant concerns.

QS22/90.6 The Executive Director of Workforce and Organisational Development asked the Committee to acknowledge that there were colleagues in YGC and across the whole of the organisation who came to work to do the right thing. That there has been significant feedback that it needs to be made easier for people to do the right thing, that the only way culture is changed is by changing behaviours and raising concerns with individuals. It was noted that currently within the organisation there were less than 10 cases of capability proceedings. She queried how feedback from discovery had been incorporated into the plan. The Acute Care Director advised that it was not in there and it was agreed that the Workforce Team would support where appropriate.

QS22/90.7   The Chair commented that at the March 2022 meeting it was

SG

requested that the overarching Action Plan should return to the Committee and that what had been received was one specific Action Plan. The Acute Care Director advised that there were individual plans but that they had not been incorporated into the one plan. It was noted that the reason for an overarching plan was due to the wider concerns that had been discussed over the previous three to four years. It was noted that the Committee understood completely that there are massive cultural issues but what was not clear was what the Hospital Management Team were doing about it and that improvements must be seen urgently. **QS22/90.8** It was agreed that a full action plan would be received at the Extraordinary QSE Committee to be convened as soon as possible. **QS22/90.9** Independent Member Jaqueline Hughes declared an interest in the item given her substantive post is in radiology. **QS22/90.10 It was resolved** that the overarching YGC Improvement Plan return to an Extraordinary QSE meeting to be scheduled as soon as possible.	
QS22/91 HIW Reports & Action Tracker **QS22/91.1** The Chair received the report with thanks noting that it was extremely helpful from an assurance perspective. **QS22/91.2** It was noted that the paper provided the Committee with an annual look-back report on HIW activity during the preceding year. As part of the Committee's return to normal business, following easing of pandemic arrangements, the report would be regularly received at QSE going forward. **QS22/91.3** The Committee discussed learning and themes it was agreed that an additional six month review needed to be included into the process. **QS22/91.4** It was agreed that the Acting Associate Director of Quality Assurance take off line the follow up process for HIW actions and provide an update at the next meeting. **QS22/91.5 It was resolved** that the Committee received the report for assurance, with acknowledgement that further work was required to provide full assurance.	 MJ
QS22/92 Mental Health & Learning Disabilities (MHLD) Update **QS22/92.1** The Committee received the updated it was noted that a project plan had been requested in relation to Co-horting including timescales. It was noted that the Department was in the process of producing this with planning colleagues. **QS22/92.2** The Interim Director Of Nursing Mental Health gave the following update in relation to the phases:	

• Phase 1 to stop admission to Hergest subject to acute care meeting discussion re clinical need and best interests - due 21 February (with one admission taking place in March) • Phase 2 to restore some admission capacity in the west area within specialist older peoples MH services in Cefni Hospital – this was planned from March to April but due to a court of Protection case it would now be July. • Phase 3 to propose to re-provide services above from Cefni hospital to the Hergest site in the former Gwalchmai ward – timing to likely to be August/September. • Phase 4 to consider the long term strategy and need for the service in the West area as part of the division's estate work – no timing noted **QS22/92.3** The Executive Director of Public Health advised that there were some high level plans and that good progress was being made, that vacancies are being managed and that work is ongoing with CHC colleagues. **QS22/92.4** The Committee discussed the overarching Improvement Plan raising concerns around the urgency that it was being developed. It was agreed that the Executive Director of Public Heath would take this forward with the Transformation Team with the full support from the Committee that the division is to be given all the tools available. **QS22/92.5** A discussion took place around ICan and what support was being provided with when coming into contact with vulnerable people who have not yet been diagnosed. It was noted that the ligature risk was presented at the risk group and was being populated to identify a wider Health Board risk, the mitigation of which is being drafted. **QS22/92.6 It was resolved** that the Committee accepted and received the update.	
QS22/93 Chair's Reports from Strategic and Tactical Delivery Groups **QS22/93.1** The Committee Received the Reports. **QS22/93.2 It was resolved** that the Committee received the reports from the Strategic and Tactical Delivery Groups and any questions would be raised outside of the meeting.	
QS22/94 Audit Wales Quality Governance Report **QS22/94.1** The Committee Received the Report.	
QS22/95 Issues Discussed in Previous Private Session **QS22/95.1** It was noted that the issues discussed at the Private Session of the	

Meeting held on 1 March 2022 were the External Serious Incident Review – MHLD: Ty Llewelyn and the External Serious Incident Review – MHLD: Hergest. **QS22/95.2** It was noted that the only discussed at the Private Session of the Meeting held on 23 March 2022 was the Ysbyty Glan Clwyd (YGC) Emergency Department Health Inspectorate Wales (HIW) report and improvement Plan	
QS22/96 Documentation Circulated to Members **QS22/96.1** There were no documents circulated to Members	
QS22/97 Agree Items for Chair's Assurance Report **QS22/97.1** The Chair agreed to reflect after the meeting.	
22/98 Review of risks highlighted in the meeting for referral to Risk Management Group **QS22/98.1** The Chair agreed to reflect after the meeting.	
QS22/99 Review of Meeting Effectiveness **QS22/9.1** Given timing the Chair agreed to reflect after the meeting.	
22/100 Date of next meeting **5 July 2022**	

	Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
**BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version**				
**4th May 2021**				
1	L Brereton	**QS21/78.2** A wider point was raised around the management of clinical policies and the route for approval. The Board Secretary confirmed she was looking at the governance route for policies with the Interim Director of Governance. The Executive Director of Workforce and OD suggested it might be helpful to consider the tiered approach taken by the Remuneration and Terms of Service Committee.	July	29.6.21 Review of policy on policies due to commence shortly, informed by governance review and approach across the Health Board. Process due for completion by September 21. 31.8.21 Governance review complete and new Integrated Governance Framework approved by Board. Further work required to identify and determine approval groups for different categories of documents (policies/procedures etc.). The review of the Policy on Policies (PoP) has commenced. However, due to significant staffing issues within the Office of the Board Secretary, the expected completion date has been put back. Provisional target date for approval at Audit Committee is now December. A project support manager has been appointed to support policy work (start date pending recruitment checks). 4.1.22 The interim Deputy Board Secretary is currently reviewing the Policy on Policies which will determine a more appropriate approval route for all policies. 18.2.22 The next iteration of the policy is being submitted to the CPPG in March, and subsequently the QSE –	

26.04.22

				3/5/22 This should be in a position to complete in time for the next committee.	July
6th July 2021					
2	~~K Williams~~ S Hill	**QS21/97.4 QPR** The Chair also referred to a narrative comment about GP consultation performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this	August	31.8.21 the separate COVID reports routinely include information on GP consultations. 7.9.21 L Reid did not feel the update above answered the original point which was that the QaPR included a narrative comment about GP consultation performance but did not include actual data. She felt this reduced the integrity of the report. This to be fed back to the Acting Director of Performance. 2.11.21 S Hill to follow up and ensure this action can be closed off. 05.01.22 The Performance team will include actual GP consultation activity in the next report. 05.03.22 To remain open as it is being tested by other Committees first.	September
1 March 2022					
3	M Marcu S Evans-Evans	**QS22/49 Corporate Risk Register Exception Report relating to Quality Risks** **QS22/49.1** Further work is required to align the BAF and Corporate Risk Register.		The BAF and Corporate Risk work is ongoing, this will go to Board in July 2022. Suggest close from QSE action log as this will be captured within the process.	July
4	M Joyes	An update on all previous Regulation 28's return to the Committee.	September	Interim position included in the patient safety report.	September

26.04.22

		Review historical R28's Pick these up as part of the clinical audit plan and test outcomes.			
5	T Owen	**QS22/53 External Serious Incident Reviews MHLD** The Executive Director of Public Health to bring back some information on the co-occurring approach.		TO will send a briefing before the next meeting.	July
	3 May 2022				
6	M Joyes	**QS22/75 Patient, Carer or Staff Story** The Acting Associate Director of Quality Assurance to investigate if there were electronic triggers available in the system to highlight if patients are dementia diagnosed when the attend in a hospital setting.		There is no specific flag within the Welsh Nursing Care Record. There is a text box to record any cognitive impairment within the system and there are intentions to review this functionality as part of further work to standardise the forms within the system on an all Wales basis. Suggest Close	
6	G Thomason	**QS22/75 Patient, Carer or Staff Story** The Acting Executive Director for Nursing and Midwifery to invite the Dementia Lead to a future meeting which would also help the Board to be reminded about their own dementia responsibilities.		An appropriate date is being sought.	

26.04.22

					■
8	J Hughes	**22/78 Minutes of Previous Meeting Held in Public for Accuracy** An Independent Member agreed to send comments to the Head of Corporate Affairs outside of the meeting.		Completed Suggest Close	■
9	M Marcu/ P Peake-Jones	**QS22/82 Clinical Audit Plan** An extraordinary meeting be convened for the full Clinical Audit Plan to be reviewed.		Meeting convened for 26/5/22 Suggest Close	■
10	G Evans	**QS22/83 Psychological Therapies Report** The Acting Executive Director Of Therapies & Health Science have the link removed from the website and the actions highlighted in the paper a reconciliation between the outcome of the actions against the original report should be noted and any reasons behind the changed be clarified.		A link to the document on the website has now been revised to a link to request access to the document. Suggest Close	■
	G Thomason/ M Marcu	**QS22/84 Dementia Hospital Charter**		An appropriate date is being sought	■

26.04.22

		Dementia Nurses to return to a Board Workshop specifically for Board Training.			■
	M Joyes	**QS22/86 Patient Safety Report** The Acting Associate Director of Quality Assurance to link in HSE into the report going forwards	July	The relevant HSE information will be captured in the report as appropriate. Suggest Close	■
	N Lyons	**QS22/88 Vascular Services** The Executive Medical Director to share the number of Vascular concerns that had been received and what other ways concerns had been received following the help line.			
	S Green	**QS22/90 YGC Action Plan** Executive Director of Workforce and Organisational Development ask the Workforce Team to support the Acute Care Director in getting feedback from discovery incorporated into the plan.		Workforce and OD Teams supporting the development and delivery of the Improvement Plan. This includes sharing the feedback from Stronger Together Discovery. Suggest Close	■
	M Joyes	**QS22/91 HIW Reports & Action Tracker** The Acting Associate Director of Quality Assurance take off line the follow up process for HIW actions		This is detailed within the Patient Safety Report Suggest Close	■

		and provide an update at the next meeting.			

RAG Status		
P		Complete
G		On track
A		Slippage on delivery
R		Delivery not on track

Report title:	Patient Story		
Report to:	QSE Committee		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	1.5 QS22.115
Executive Summary:	The digital patient story will be played at the meeting. A short summary is included in the attached paper.		
Recommendations:	The Committee is asked to receive and reflect upon the patient story.		
Executive Lead:	Gaynor Thomason, Interim Executive Director of Nursing and Midwifery		
Report Author:	Matthew Joyes, Associate Director of Quality		

Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☐

Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

In line with best practice, the patient story is presented to the Committee in order to bring the voice of the patient directly into the meeting; it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.

Link to Strategic Objective(s):	Quality
Regulatory and legal implications	N/A
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	N/A
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	N/A
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	N/A
Reason for submission of report to confidential board (where relevant)	N/A

Next Steps: N/A

List of Appendices: Patient Story summary sheet – digital story will be played in the meeting

Betsi Cadwaladr University Health Board
Nicola's Story

A video story told by a member of staff on behalf of Rebecca will be played at the meeting.

Overview of Patient Story

I would like to share the experience my daughter and I received when we attended the Emergency Department in Glan Clwyd Hospital after my daughter had a bad fall on the evening of 01 April 2022.

The fall had resulted in obvious facial fractures and had left my daughter in an extremely distressed and agitated state. I am a registered health professional, so when I witnessed the injuries that my daughter had sustained I knew she needed urgent medical attention, so I brought her straight to the Emergency Department where we were both received exemplary treatment.

When we arrived at the Emergency Department, I was extremely anxious about my daughter and I must have looked so frightened that two lovely Security Guards immediately approached me to ask how they could help. I explained the situation and they very kindly and carefully helped my daughter from the car and stayed with her whilst I booked her in at reception.

We were immediately greeted in the Emergency Department by Clinical staff who quickly assessed the situation and took my daughter directly to Resus, where we stayed until the following day. During the night, my daughter was cared for by a variety of staff members including clinicians from the Emergency Department but also from ENT and Maxfax, all of whom were conscientious and thorough but still delivered care with kindness and compassion.

Summary of Learning and Improvement

Rebecca's story has been shared with staff at Ysbyty Glan Clwyd ED department and with the Estates Team.

Key learning points shared:

- Overall excellent experience of busy Emergency Department from the perspective of both patient and carer.
- Staff provided sensitive and appropriate care.
- Staff acknowledged the need for a patient's loved one to accompany them throughout their journey.
- Clinical staff from multiple disciplines attended to patient in a timely manner.

- Security staff contributed to care of patient with care and compassion.

This story highlights a positive experience and as part of our commitment to build a learning culture from patient experience, the learning from positive experience is equally important to ensure all people who use of services receive a consistently positive experience of their care.

The Patient and Carer Experience Team will share this feedback and seek assurance from departments by way of evidence that learning has been embedded.

The Patient and Carer Experience Team extend their gratitude and appreciation to Rebecca for sharing her story.

Report title:	Executive Lead for Quality – Briefing Paper		
Report to:	QSE Committee		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	1.6 QS22.116
Executive Summary:	This paper provides the Committee with the Executive Lead for Quality Briefing Paper.		
Recommendations:	The Committee is asked to note this report.		
Executive Lead:	Gill Harris, Interim Executive Lead for QSE		
Report Author:	Matthew Joyes, Associate Director of Quality		

Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☐
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
This paper provides a summary of key quality highlights – further detail is contained within specific papers and reports to the Committee.	
Link to Strategic Objective(s):	Quality
Regulatory and legal implications	N/A
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	N/A
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	N/A
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	N/A
Reason for submission of report to confidential board (where relevant)	N/A
Next Steps: N/A	
List of Appendices: Executive Lead for Quality – Briefing Paper	

Executive Lead for Quality – Briefing Paper – July 2022

This paper offers a summary of key quality information for the preceding period between meetings. Detailed information is contained within the reports presented to the Committee. The Committee is advised this report is live to the point of finalisation and therefore may present more detailed information than that within reports that cover a set reporting period.

Patient Safety Incidents

During April and May 2022, 20 nationally reportable incidents were reported, down from 42 in February and March 2022.

Zero Never Events were reported.

Further information is included in the Patient Safety Report including a summary of the main themes and the improvement work planned and underway.

The human factors training, provided by AQUA, has now commenced for cohort 1. Two further cohorts will commence over the coming months. The staff completing this training will become part of our emerging human factors faculty.

NHS Wales Delivery Unit Review

In May 2022, The NHS Wales Delivery Unit (DU) National Quality and Safety Team visited the Health Board by invitation to observe a number of quality and safety functions, and provide in-person feedback on incident management within the Health Board.

The feedback stated: "*Overall, the DU feedback was highly positive with the approach, focus and quality of functions observed and discussed with the Health Board's corporate senior team responsible for quality. There was clear evidence of a patient centred approach and focus to the Q&S agenda, with the team demonstrating positive leadership and a commitment to achieve high standards across the organisation.*"

No significant concerns were raised. A number of recommendations have been made which are currently being reviewed, and at the request of the Chief Executive will form an improvement project. Full detail will be included in the next Patient Safety Report as the DU feedback as received after the current report was drafted.

Inquests and Regulation 28 Notices

During April and May 2022, 3 new Regulation 28 (PFD) reports were received by the Health Board. In brief, these notices cover:

- Medication practice in community nursing;
- Delay providing evidence of completed actions and changes in working practices;
- Ambulance handover delays (issued jointly to BCUHB and WAST).

One of these notices has been responded to covering medication practice. Further information is included in the Patient Safety Report.

Patient safety incidents following nosocomial transmission of Covid-19

The Health Board continues to adhere to the National Wales Framework Guidance to provide a consistent approach for NHS Wales organisations to identify, review and report patient safety incidents following nosocomial transmission of Covid-19 in compliance with the National Health Service (Concerns, Complaint and Redress Arrangements) Regulations 2011 – Putting Things Right.

The Investigations will be completed in line with the NHS Wales National Framework – Management of patient safety incidents following nosocomial transmission of COVID-19. This includes investigating cases where a person has acquired nosocomial COVID-19 in a care setting while receiving NHS funded care and when individuals were transferred from hospital into a care home and subsequently contracted COVID-19, within 14 days of transfer.

The Health Board are in continuous contact with the NHS Wales Delivery Unit and neighbouring Health Boards to share best practice. The Health Board have adopted a proactive approach to engage with the families of those affected with the nosocomial transmission of Covid-19 to include them as part of the proportionate investigations. The Health Board will encourage meeting families in person to explain, but more so to let them "tell their story". The feedback to date has highlighted the importance of being able to discuss openly in their language of choice i.e. Welsh/English. The Health Board will also encourage staff involved in the patients care to participate in the conversations with families and support staff to understand what patients and families were going through at the time.

Timely learning extracted from investigations and information presented as an action/improvement plan in preparation for any future waves, currently by way of circulating information with infection prevention and control colleagues via Safe Care Harm Free workstream.

Patient involvement: Long COVID

Patients diagnosed with Long Covid who expressed an interest in becoming Long Covid Lived Experience Representatives have been working with clinical staff to co-produce the new Long-Covid clinical pathway. A Long Covid Partnership Group was established with patients playing an important role in decision making to ensure the voice of the patient is heard throughout the development of this service.

Patient feedback and engagement, through the recruitment of Lived Experience Representatives, has played a pivotal role in influencing service design and implementation of the Long Covid-19 service at BCUHB. This model of good practice developing lived experience groups is to be rolled out across service areas.

Regulatory Activity

On the back of the inspection in March, HIW undertook an unannounced inspection of the Emergency Department at Ysbyty Glan Clwyd between 03 - 05 May 2022. During the quality check HIW found immediate assurance improvements were required around timely access, record keeping, managing risk, medicine management and governance and leadership. An Immediate Assurance Improvement Plan was submitted to HIW for assurance.

Consequently HIW considered their findings and evidence following a No Surprise Notification in January along with the inspection in March and May 2022. HIW has determined that the Health Board has not been able to demonstrate sufficient progress against several key areas of concern relating to patient safety and quality of care.

The Emergency Department at Ysbyty Glan Clwyd was considered and consequently identified as a Service Requiring Significant Improvement.

The service remain under this status until such time that HIW de-escalate the service from this status. The Health Board await further details from HIW in terms of their planned approach to this.

Significant support has been put in place to the YGC team, and this issue was discussed at the extra-ordinary QSE Committee on 26 May 2022. A separate paper is presented to the Committee on this.

The inspection report from March was published by HIW on 18 May 2022.

Further information is included in the Patient Safety Report. This includes a copy of the HIW inspection report issued on 19 May 2022 regarding YGC.

Nutrition & Hydration

The Patient and Carer Experience Team in the East identified an increase in the number of PALS enquiries relating to nutrition at Wrexham Maelor Hospital. A patient story was captured sharing a patients experience as an inpatient at Wrexham Maelor Hospital where she was not given meals to support her dietary requirements. As a result of learning from the patient story and taking into consideration PALS feedback, a Nutrition and Hydration Improvement Group was set up focus on improving nutrition standards in patient meals at Wrexham Maelor Hospital. The purpose of the group is to develop a programme of quality and improvement looking at nutrition hydration across the hospital ensuring patient and carer experiences are being shared.

Gynae Voices

The Health Board was cited in the Royal College of Obstetricians and Gynaecologists Workforce Report in 2022 providing a case study detailing the work they are leading on with patients.

The Gynae Voice Forum is multi-professional, bringing together those who use and those who provide gynaecology services within the health board and has a wide and varied participation from women across the region with a wide spectrum of gynaecological conditions. Patients have been involved through these various ways:

- The Gynae Voice forum provides a vital and regular opportunity for women to engage with local service providers as equal partners in the design, delivery, and evaluation of the healthcare services they use.
- Women know their voices are being heard – they have actively participated in the development of new initiatives and services including a successful business case for a specialist menopause clinic in North Wales; development of outpatient hysteroscopy services; a review of fertility and endometriosis service pathways and provisions; an audit of patient-reported outcome measures in minor gynaecology procedures.
- Health Board staff can bring questions to patient members, including around content and style of written communications with women, guidance for clinicians and possible new service models.
- Patient members can bring issues of concern to the Health Board.
- Involvement of Gynae Voices provides assurance to other women that gynaecology services are person-centred.
- Co-production helps to ensure efficiency and better outcomes by embedding person-centred care, needs, and preferences right from the start of the design process, rather than consulting on services afterwards.

Ockenden Review of SaTH

As updated in the last report, the Health Board continues to work with Welsh Government colleagues and the national maternity network to ensure the learning from the Ockenden Review of Shrewsbury and Telford NHS Trust is embedded across Wales. The incoming Director of Governance will support this work within the Health Board.

Additionally, the Health Board is actively engaged in the National Maternity & Neonatal Safety Support Programme launched by Welsh Government. A national lead from the project will be visiting the Health Board for a three day visit in July to specifically look at patient experience and patient engagement.

Quality Recognition

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

Report title:	North Wales Community Health Council (NWCHC) Safe Space report on Speech and Language Therapy (SLT) services.		
Report to:	Quality, Safety, Experience Committee		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	2.1 QS22.117
Executive Summary:	This paper highlights the key learning points from a NWCHC report and presents a service plan in response. The plan has been written by the Heads of SLT and agreed by the SLT Steering Group.		
Recommendations:	The Board is asked to: Consider the findings of the NWCHC report and the service plan to address the identified learning points.		
Executive Lead:	Gareth Evans, Acting Executive Director Therapies&Health Sciences		
Report Author:	Liz McKinney, Cara Spencer, Dawn Leoni (Heads of Service SLT)		

Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

- The plan has been discussed and agreed at the BCUHB SLT Steering group
- Links to existing work in place as part of Covid recovery planning
- Unplanned staff turnover/sickness absence impacting service provision could pose a risk/delay in delivery (hence 'acceptable assurances' rather than 'significant assurances')

Link to Strategic Objective(s):	Living Healthier Staying Well, Covid recovery, planned care improvement.
Regulatory and legal implications	Not applicable
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	There is a current risks linked to staffing and access within SLT services.
Financial implications as a result of implementing the recommendations	None
Workforce implications as a result of implementing the recommendations	The plan will support workforce recruitment and retention
Feedback, response, and follow up summary following consultation	The action plan was presented and agreed at the SLT Steering Group on the 30th May 2022
Links to BAF risks: (or links to the Corporate Risk Register)	BAF21-04 Recovering access to timely planned care pathways BAF21-18 Workforce optimisation
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:
Implementation of the Plan on Page (Appendix B) in order to address the following areas:
- Stakeholder communication and Feedback
- Workforce recruitment and retention
- Recovering waiting times for intervention

MEETING IN PUBLIC Tuesday 5th July

North Wales Community Health Council (NWCHC) Safe Space report on Speech and Language Therapy (SLT) services.

1.   Introduction/Background

In June 2016, a member of BCUHB staff raised formal concerns about aspects of the BCUHB Speech and Language Therapy Services in the West. An investigation was commissioned in response to these concerns under the All Wales Raising Concerns Policy and nineteen recommendations were made. BCUHB established a Speech and Language Therapy Steering Group accountable to the Area Director West to provide the oversight for the implementation of the recommendations. The NWCHC was invited to become a member of the Group, as 'observers with speaking rights'.

One of the recommendations was to review the existing fora for gaining service user and partner feedback. The NWCHC kindly agreed to undertake work to gather the experiences of patients, relatives, carers and other stakeholders. It was also agreed that it would be valuable to be undertaken for the whole of Speech and Language Therapy services across North Wales rather than just the West Area. The NWCHC used its Safe Space methodology combining virtual and face to face events to assist with accessibility.

The service is keen to improve and extend the way in which it captures user and carer feedback. The views and stories of those who access Speech and Language Therapy in North Wales helps us understand the lived experience of those who use the service. Taken along with a range of other relevant information about the service, this provides a foundation for both sharing good practice and identifying opportunities for improvement.

This paper highlights the key learning points identified from the NWCHC report and presents the service plan in response. The service plan has been written by the Heads of Speech and Language Therapy in BCUHB and agreed by the Speech and Language Therapy Steering Group. This will ensure that the CHC report is used for its intended purpose; that of improving care and user experience. Whilst the original recommendation related to an investigation in the West Area all three Speech and Language Therapy teams in North Wales have worked together to use the findings to ensure a consistency of response and to ensure that using service user feedback becomes an ongoing and positive process to achieve better outcomes.

2.   Body of report

The SLT service welcomes the NWCHC report (Appendix A) and thanks them and all the individuals who participated for sharing their personal experiences and ideas openly. There is a full commitment to learning from the messages in the report. The service has developed a Plan on a Page (Appendix B) to provide assurance of the actions in response to the NWCHC report. This plan has three key components.

Speech and language therapists work with babies, children and adults in clinics, nurseries, schools, hospitals, nursing homes, day centres, clients' own homes, and within the justice system. They work within multi-disciplinary and multi-agency teams across health, education and social care to support people of all ages who are experiencing communication and/or swallowing difficulties. Within BCUHB, SLT services receive around 7000 referrals a year across North Wales. At any time, there are around 5000 children and around 1000 adults receiving continued SLT care across the region, and the service provides upwards of 50,000 patient contacts each year during usual times.

Whilst only a very small number of people (25) participated in the engagement events organised by NWCHC the services knows that it needs to work harder to provide accessible feedback opportunities for the people who use our service, many of whom have communication difficulties, to be able to share their experiences so we can learn from them. **An ongoing commitment to stakeholder communication and feedback is therefore the first of our 3 components.**

The NWCHC report referred to recruitment challenges affecting the available SLT service. SLT is a recognised shortage profession across the UK, and BCUHB have recruitment challenges that are not unusual within the NHS at this time. Whilst SLT vacancy rates through the pandemic have generally been lower than a BCUHB average, there is concern about the ability to retain and grow our workforce in the context of increasing need.

There is recognition of the challenges of recruiting SLTs who have Welsh-language competencies to enable them to provide care bilingually where it is needed. Our current staff groups have different proportions of Welsh language competency, which reflect the different populations they represent and serve. Current data shows:

Area	% SLT staff with Level 4 – 5 Welsh Language Competency (ESR data Aug 2021)	% population Welsh language speaking (Census 2011)
Anglesey	WEST AREA 69%	57.2%
Gwynedd		65.4%
Conwy	CENTRE AREA 30%	27.4%
Denbighshire		24.6%
Flintshire	EAST AREA 14%	13.2%
Wrexham		12.9%

Therefore, workforce recruitment and retention forms the second of our 3 components.

The NWCHC's report outlines important messages about the impact of the Covid-19 pandemic on SLT services, which will not be unique to BCUHB. Welsh Government directives to suspend planned care at critical peak times during the pandemic were

followed to keep patients and staff safe and to enable the health service's Covid response. During the NHS' initial Covid response; around one third of SLT staff within BCUHB was re-deployed. Despite some service recovery continued restrictions across health and education settings and high levels of workforce absence have reduced our capacity. Our referral rate dropped dramatically during the pandemic, particularly in children's services, as those services who usually refer to us (including schools and health visitors, for example) were also operating very restricted services. This is a concern for those children in need of our support. We are reassured that this is steadily improving and now similar to pre-pandemic levels, and we share the concerns expressed by many of the impact of these disruptions on the progress of children and the complexity of difficulties some now present with. SLT's professional body, the Royal College of Speech and Language Therapists, have engaged with SLT services across the UK, providing up to date professional guidance to support the recovery and restoration of children's SLT across the country, which will continue to inform our work in BCUHB. **Improving access to our services and recovering our waiting times for intervention (which are now generally longer than usual following the pandemic), forms the third of our 3 components.**

The more detailed actions that underpin these three components can be seen in the SLT Plan on a Page in appendix B. Oversight of the delivery of the plan will initially be through the existing three Area quality and safety structures. This responsibility will transfer to the Health Communities within the new operating model once they are established.

3.   Budgetary / Financial Implications

3.1   There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by each of the Heads of Service in Speech and Language Therapy

4.   Risk Management

4.1   There is one current risk on Datix linked to this report. The risk ID is 2233 and relates to a risk that therapy services will be unable to recruit sufficient Welsh speakers for their SALT service provision. The risk is partially mitigated.

5.   Equality and Diversity Implications

5.1   This report does not relate to a strategic decision therefore an EqIA and SEIA are not required.

APPENDICES

Attached separately

North Wales Community Health Council

Speech & Language Therapy Services

Engagement Events

**Final Report**

March 2022

Contents

Introduction

This report has been produced by North Wales Community Health Council (NWCHC)

NWCHC is the independent watchdog for NHS services in North Wales and we seek to encourage and enable members of the public to be actively involved in decisions affecting the design, development and delivery of healthcare for their families and local communities.

NWCHC works with the local NHS, as well as inspection and regulatory bodies, to provide the crucial link between those who plan and deliver the National Health Service in North Wales, those who inspect and regulate it, and those who use it.

NWCHC maintains a continuous dialogue with the public through a wide range of community networks, direct contact with patients, families and carers through our enquiries service, complaints advocacy service, visiting and wider engagement activities and through public and patient surveys.

NWCHC represents the "*patient and public voice*" within the geographical area covered by Betsi Cadwaladr University Health Board (BCUHB).

North Wales CHC
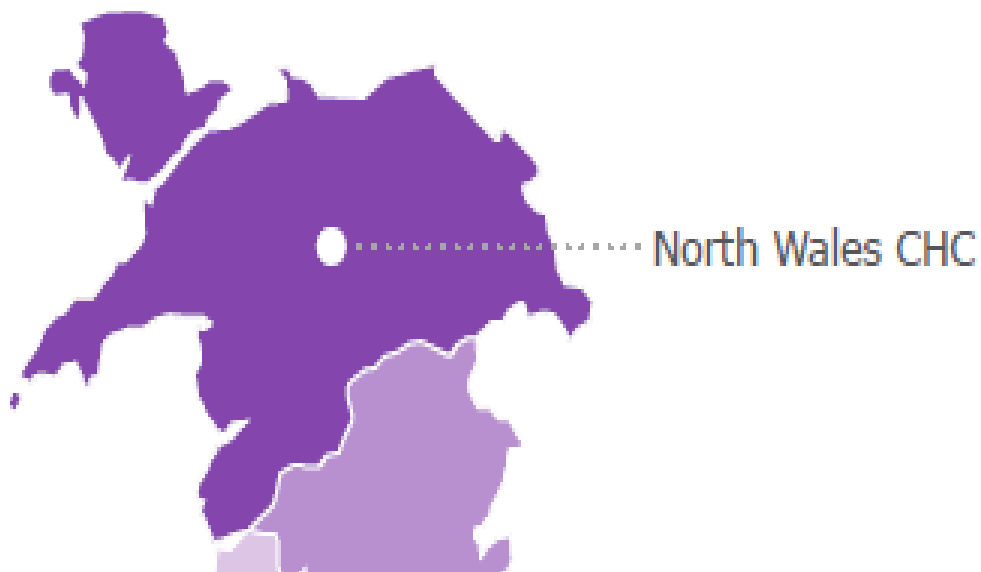
Background Information

In June 2016, a member of BCUHB staff raised formal concerns about aspects of the BCUHB Speech and Language Therapy Services in the West. An investigation was commissioned in response to these concerns under the All Wales Raising Concerns Policy and a number of findings and recommendations were made.

BCUHB established a Speech and Language Therapy West Steering Group (the Group) (accountable to the Area Director West) to provide the oversight for the implementation of the recommendations. The NWCHC was invited to become a member of the Group, as 'observers with speaking rights'.

One of the 19 recommendations made following the investigation, was for the Group to review the existing fora for gaining service user and partner feedback, in particular with the Local Education Authorities and Universities.

It was proposed that in partnership with the BCUHB, the NWCHC (*being the independent health watchdog for the region*) would explore the possibility of a combination of virtual and 'face to face' engagement events. The events could be undertaken with a view to gathering the experiences of patients, relatives, carers and other stakeholders of the Speech and Language Therapy services (SALT) across North Wales.

It was further proposed that a series of events were arranged by the NWCHC and that they would follow a similar format to the NWCHC 'Safe Space' events in respect of Vascular Services (October 2019 – January 2020) and Mental Health Services (December 2020 – March 2021).

The NWCHC undertook an extensive publicity campaign, promoting the events through its networks, including the press, social media, schools and colleges, town and community councils, and Local Authorities, care/ nursing and residential homes, school language centres, community groups and organisations, nursery school and Cylch Meithrin, GP practices, MPs and MS's and Voluntary Services Councils.

Methodology

NWCHC has extensive experience of undertaking public engagement and formal consultation exercises across North Wales. Our experience has enabled us to develop wide-ranging networks across the region and to build upon our resources and tools for undertaking public engagement.

Since March 2020 and in light of COVID-19 restrictions, the NWCHC has acquired the technology and skills to undertake virtual meetings.

The NWCHC held five virtual events, with each event focusing on broad themes of Speech

& Language Therapy services in North Wales:

Additionally the NWCHC held eight face-to-face events. These events were by invitation only in order to ensure that appropriate social distancing measures could be put in place. These events were not open to attendance by BCUHB staff.

At the start of each session we asked people about their experiences during the pandemic. It is clear that Covid has had a huge impact on service delivery and on patients themselves.

Although the events were intended to cover all aspects of Speech & Language Therapy in North Wales, the majority of those who attended wanted to discuss Child Speech & Language Therapy Services – specifically those related to speech and language delay.

Following the events, some of the individual cases shared with the NWCHC were followed up with meetings between the parent, BCUHB managers and the NWCHC managers. The meetings aimed at supporting the parents and resolving their queries. We would like to thank BCUHB for its willingness to meet with parents and to listen to their concerns.

This report contains all recorded comments of the 25 people who have contributed so far and attempts to identify themes, trends and learning issues.

Structure of the Events

All events began with an explanation of the role and function of NWCHC and an outline of the nature and purpose of the events. This included details of the ways in which information shared would be used; the importance of confidentiality within the events; that information would need to be shared in the event that evidence of serious harm or potential criminal wrong-doing came to light.

Discussions were based around the '7 C's';

Compliments, Comments, Concerns and Complaints; Care planning and Care delivery; Communication and engagement.

It was envisaged that some people might not have wanted to be part of any group discussion and might wish to talk on a one-to-one basis. All participants were informed that this could be arranged.

Timetable of Events

Date	Location
07 September 2021	Porthmadog
29 September 2021	Connah's Quay
01 October 2021	Glyndwr University Wrexham
04 October 2021	Zoom
11 October 2021	Zoom
20 October 2021	Zoom
08 November 2021	Zoom
09 November 2021	Ty Pawb, Wrexham
10 November 2021	Zoom
11 November 2021	Denbigh
17 November 2021	Flint
18 November 2021	Bangor
06 December 2021	Llanfairfechan

The events were arranged to take place in a number of other locations across the North Wales region. Some of these were cancelled as those who wished to take part preferred to contribute via Zoom, telephone or written communication. Others were cancelled as there was little interest shown in those particular locations.

Impact of the Pandemic

Most of those wanting to speak about their SALT experiences were parents of children using the service – principally delays in accessing the speech and language service. We heard that following the first UK-wide lockdown beginning on 23rd March 2020, sessions for children almost completely ceased until September 2020. For much of this period there was little or no contact between families and Speech and Language Therapists. Later some received services by video conference but some parents told us that services only appeared to restart post-September 2020 because they were persistent in calling for services to their children to start again.

Many parents told us that they felt their children had lost services at a crucial stage in their development and that this was compounded by the absence of interaction with other children due to home schooling. Some parents felt that their children had lost all progress made in previous months and that the effect upon their child's development had been devastating.

Parents acknowledged that the pandemic had presented everyone, including SALT, with extreme challenges and that it had been necessary to redeploy staff to deal with vaccinations and care for sick patients in hospital. However, they also felt that more could have been done to continue contact with children using the service, albeit in a limited way, using video conferencing and digital technology.

Staffing levels and recruitment difficulties within SALT, both before and during the pandemic, have been a major challenge to providing the service.

We believe that it is because of this hiatus in child speech therapy, that most of our contact was with parents of those children. An additional factor may have been the effectiveness of NWCHC communication via school emails and apps.

BCUHB – Initial comments and proposed actions following receipt of this report

'Betsi Cadwaladr University Health Board welcomes this report from the North Wales Community Health Council into Speech and Language Therapy Services in North Wales. As the report notes, we are keen to improve and extend the way in which we capture service user and carer feedback with a clear intent to utilise the findings to improve services. The views and stories of those who access Speech and Language Therapy in North Wales helps us understand the lived experience of using our service. Taken along with a range of other relevant information about the service, this provides a foundation for both sharing good practice and identifying opportunities for improvement.

We therefore expect to explore the unique user and carer perspectives captured within this report to understanding the care they have experienced as a basis of developing the insight necessary to learn and develop the service. The report will initially be considered by the Health Board's Speech and Language Therapy Steering Group under the leadership of the Area Director West. This will ensure that the report is used for its intended purpose; that of improving care and user experience. The three Speech and Language Therapy teams in North Wales will work together to use the findings to ensure a consistency of response and to ensure that using service user feedback becomes an ongoing and positive process to achieve better outcomes.'

BCUHB February 2022

What people told us

The following case examples are the experiences, as recounted to the NWCHC, of the people who spoke to us during and immediately following our engagement events.

Stroke Rehabilitation

We spoke to an older patient who had used the SALT service based at Dolgellau Hospital following a stroke. The patient told us that;

- The service provided by Dolgellau hospital was working very well
- During the pandemic their Speech and Language Therapy had been undertaken remotely using Zoom. They felt that had been very effective and tailored to their needs. They told us that this had been much better than face to face Speech and Language Therapy with masks.
- The patient was very complimentary about their Speech and Language Therapist and Occupational Therapist, both based at Dolgellau Hospital. They told us that they had focussed closely on the patients' particular needs and had worked closely with the patient to facilitate their personal recovery with both their speech and their physical recovery.
- The patient reported that the Speech and Language Therapy had been undertaken at the correct pace for them, the Speech and Language Therapist being patient and empathetic.

Laryngectomy

We spoke to a patient who had undergone a laryngectomy following throat cancer. They had had treatment in both Ysbyty Glan Clwyd and Clatterbridge Cancer Centre. They now have no larynx and can no longer speak naturally. They now use a throat audio device called an artificial Electro Larynx (EL) to speak. They told us that this device is not funded by NHS Wales. *(We have subsequently learnt from BCUHB that the NHS does fund these devices and have confirmed this with the patient).*
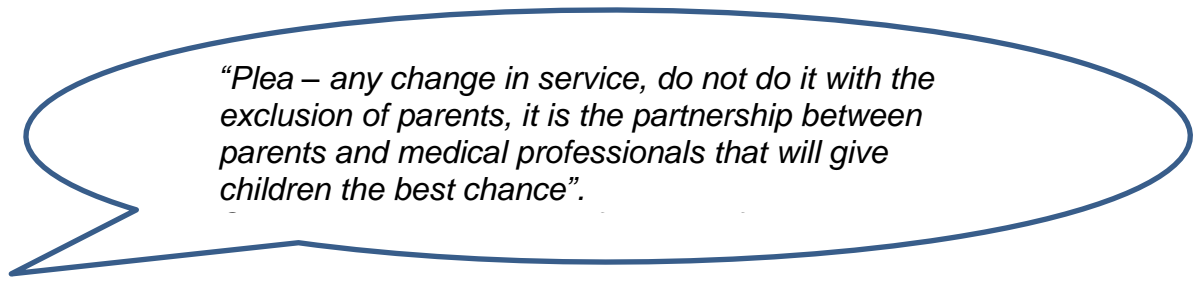
The patient also told us they had received good support from SALT both before and after their laryngectomy, this included help to relearn to eat safely. They said their therapy had worked well but they felt they would have benefitted from more individual time and a wider range of therapies made available, particularly in learning to speak using the Electro Larynx.

They advised us that the EL isn't easy to use. Following the laryngectomy it is necessary to wait until the swelling has gone down, then to find the correct area on your neck for it to be effective. This is the "*sweet spot*" and it is also dependent on which hand is used to position the EL. It took the patient a long time to re-learn to speak, practicing and repeating various vocalisations in the mouth such as vowel sounds. They learned with several other laryngectomy patients - so there was group support which made it easier to practice and find out what worked for each individual. It was the patient's view that users of the Electro Larynx are the best teachers. The patient told us that the Laryngectomy Group hold fundraising events in order to purchase more to give out at their events where needed. Volunteers from the group train new users to speak with them. The BCUHB has told us that

they recognise the great work that the Laryngectomy Group undertakes to support core NHS services.

The patient believed that the Laryngectomy Group had been essential in getting them to the stage they are now at with their speaking. https://glanclwydlary.weebly.com/

Child Speech & Language Therapy Services

"Plea – any change in service, do not do it with the exclusion of parents, it is the partnership between parents and medical professionals that will give children the best chance".

Whilst the experiences we heard were specific to individual children, there were several themes that we heard consistently:

- Little or no service between March and September 2020
- Face to face services were not generally replaced by video-conference (VC) during lockdown (*as were school lessons*). VC SALT services would have been welcomed by most parents during lockdown.
- Parents told us that they had to "*fight*" to get the service they believed their child needed. One parent told us:

    "*If a child is lucky enough to have a parent who fights and asks questions and makes themselves a pain, they will have a better outcome*".

- Some children did not pick up the service post-lockdown, becoming lost to the service. Many of those we talked with felt their child had suffered delayed development as a result of lost therapy and isolation.
- Staffing levels and recruitment issues are affecting the service throughout North Wales and have an effect on consistency and regularity of service.
- Recruitment of Welsh-speaking Speech and Language Therapists is a major problem
- Lines of demarcation between the NHS and Local Education Authorities are seen as unhelpful by parents and damaging to the progress of their children. Parents expect a seamless service.
- Parents were concerned that, because of the staffing shortages and recruitment problems, staff were prioritising cases where results could be delivered quickly and that more complex cases were being left behind.

Child A - We saw a Mum of an 11 year old at a 'face-to-face' session at Glyndwr University. She told us that her child had waited over a year for their initial assessment and that she had experienced similar delays in relation to Education. Like many of the parents who contacted us, she felt she had to "*fight for everything*". She has made formal complaints to

BCUHB and the LEA and has been dissatisfied with the outcome of both.

Her child was initially seen in January of 2019. The family were given a '*strategy pack*' and the child was then discharged. Mum asked for a re-referral. An assessment was undertaken and the report stated that there was nothing wrong even though the child had displayed some speech and language issues. Unfortunately, there was a data breach and the report was sent unencrypted to the wrong school. Mum said she wanted to make a formal complaint but this was not progress and she did not receive a written apology.

At this point mum paid for a private Speech and Language Therapy assessment. This used the CELF V5 assessment package (*SALT use an earlier version*). As a result of this report, her child has now been statemented due to developmental language delay. The statement says that the child needs weekly SALT support to be provided by school.

Wrexham Council wanted to place the child in a secondary school that, mum feels, would not be able to meet the child's needs. In consequence, the child now attends a private school in England. Although the family live in Wrexham, SALT has declined to provide the child with a service because the school is "out of district". No offer of Zoom or Teams appointments have been made.

Child B - We spoke to a Mum in the Central Area who has a child who has received SALT services since they were 2 ½ years old. The child is now six and still needs help.

When in nursery school, the child saw a Speech and Language Therapist in Ruthin for half an hour per week. They were subsequently referred to a Speech and Language Therapist in Denbigh. This went well until the therapist went off on sick leave. Despite chasing up regularly, Mum heard nothing about replacing these sessions.

When the child started school, they started to receive some Speech and Language Therapy input again but once the pandemic started, they did not see anyone at all. The child was offered a Zoom session but finds it hard to concentrate and needs to be seen face to face. As a result, the child has not seen a Speech and Language Therapist since March 2020.

When the child returned to school after lockdown, one of the school's Teaching Assistants started doing some speech exercises with the child. They have seen some improvement in the child's speech but last time Mum took the child to see a physiotherapist for another condition, the physiotherapist could not understand the child. Mum also feels that after two years without contact with SALT, it is now time to reassess the child.

Child C - At a Zoom session on 4th October 2021 we spoke to a Mum who had made a parental referral to SALT in October 2020. SALT were quick to respond and provide an assessment. However, the sessions provided (4) were with a nursery nurse and not a trained Speech and Language Therapist – perhaps due to staff shortages. The sessions were useful, advising basic things that the family were already doing such as reading with the child. However, the sessions were not, Mum felt, pitched at the appropriate level to move the child on. All appointments were over the telephone, there were no face-to-face appointments available.

Mum tells us that the school is now concerned that her child is not receiving the Speech and Language Therapy input that they need. She has been told that there will be a long wait for

a second SALT assessment. Her child's behaviour has deteriorated due to continuing difficulties in communication with school staff and other children. Accordingly, she is now considering a private neurodevelopmental assessment in order to provide the school with a development plan.

Child D - Also on 4th October, we spoke to the Mum of an adopted child. The child had been a patient of SALT from the age of three, prior to adoption.

Mum attended every appointment and had the impression that the service being delivered is not integrated across the range of a child's needs; her child would receive support with individual letters i.e. how to pronounce R, how to pronounce J. Getting the child to repeat letters over and over did not help with the child's speech and clarity of speech. As a result, the Speech and Language Therapist said that although the child could not speak intelligibly, the child had no problem pronouncing individual letters. Mum was told that SALT could only help with letter pronunciation and they could not help with overall speech. They said they could not refer to anyone who could help.

Mum felt that SALT were not able to support a 'looked-after' child with behavioural issues.

In 2020, the child was referred to a Speech and Language Therapist who was able to identify the child's needs and was supportive. Her input was positive and helpful after many years of difficulty and it was felt to be a tragedy when she moved on from the department.

In Mum's experience, there is a lack of urgency in addressing children's Speech and Language Therapy needs. She felt that delays at a time when children are developing and changing so rapidly could have a huge impact on their development.

> *"He has had to go outside of his home for his therapy. He has been distracted by his unfamiliar surroundings so it didn't work as well as a home visit".*
>
> *"He was seen in a very small room that had a big yellow bin, a sink and a tap and some chairs. It was a very strange, anxiety-inducing environment for a child".*

Child E - At a face-to-face session in Denbigh on 11th October, we spoke to the Mum of a six year old. Her child was first referred, by her, to SALT at the age of three years. Prior to the pandemic the child received two or three sessions in Plas Dyffryn and another two in Denbighshire Infirmary. One of these sessions was cancelled but they were not informed beforehand.

The child has seen several Speech and Language Therapists. This was troubling to the child because there was a lack of consistency and the child was meeting a stranger each time. On one occasion, Mum was told her child had issues with their attention span (*at aged three*) and at the next appointment, they were told that this was not mentioned in the child's medical records.

The child was sent for an Audiology appointment to check if the child's hearing was normal

and they sat for an hour before being asked why they had booked an 'adult appointment' for a child. The appointment had been arranged by the Speech and Language Therapist. Nevertheless, the Audiologist completed the test and concluded the child had no hearing problems.

Mum tells us that there has been no contact with SALT since September 2020 and the child's speech and language problems have not been resolved.

The child is receiving help from an Educational Psychologist in school but the material being used is that which was provided three years ago.

Mum is concerned that they have no single point of contact with SALT, no current information or support and no diagnosis. The family needs to know what is going on at this crucial time in the child's development. She would like a care plan, a point of contact, updated materials and exercises that could help at home.

Child F – (*received by email)* Mum told us that her youngest child had speech dysfluency from the age of three. The child was referred to a Speech and Language Therapist who worked very well with the child. However, she resigned/left the post after approximately 4 months.

Mum recalls that active therapy stopped at that point. Perhaps due to the shortage of Speech and Language Therapists. She informed us that she was told that a new Speech and Language Therapist had been employed in the area but all that would happen on attendance, was that Mum would take time off work, take her child out of school and go to a local community hospital to meet the new therapist, thinking that "*therapy*" was to begin. However it was always 'an assessment' - always culminating in - "*yes the child needs to have therapy but this therapist wouldn't be around to do it*". She said that this was repeated many times and always involved an assessment but no therapy. Mum said that when her child did see somebody locally… she did not seem to have any real knowledge of treating 'dysfluency'.

Mum spoke to a therapy senior manager at BCUHB who told her that "*there wasn't much that could be done. Dysfluency and most of it was down to what parents did with the child at home*".

Mum went on to say;

> "*I got onto the Michael Palin Centre in London who said they would be happy to see my child but it should really be a service provided locally and be integrated with my child's school etc. I even had a talk with a recommended therapist from Israel online who again advised that dysfluency in a child should be treated in my child's environment (local therapy, school involvement etc). I took my child to an Australian therapist in Ireland who was great but advised that therapy needed to continue in Wales - I tell you this so as to let you know that we were very motivated to get my child help.*
>
> *I did eventually lodge a complaint. This went through all the rigmaroles of a formal complaint - culminating in my husband, myself and my child attending a review locally - this resulted in a new treatment plan of sorts -which was*

ineffective.

So, many years later where are we? Well, there has never been a follow up for my child. Nobody has checked to review etc. I got the impression that there were no permanent therapists available. It seemed all about assessing only, almost like this equated to meeting some kind of target. I gave up on BCUHB for therapy.

I can only apologise for being so negative but my experience with Speech and Language Therapy in North Wales (via BCUHB) was a very negative one. I hope things have improved since."

Child G - Received by email:

"*I am writing to you with a few concerns with regard to how my child has been dealt with since they were 2 years old by various parts of the health board. My child is now 9 years old. I recently put in a complaint regarding Speech and Language Therapy and the lack of access and support my child has had over the years. I have now received a copy of the investigation and I'm not sure how to proceed from here.*

I believe that the concerns raised in the report have directly impacted my child's access to other services such as CAMHs and neurodevelopmental team and instead of working collaboratively it caused a long game of ping-pong with my child at the centre of it. My child was left unsupported with me trying to get help on and off for years, culminating in my child being unable to attend school since April this year due to anxiety caused by unmet and unidentified needs".

Child H – By telephone:

Mum has a child who has been receiving SALT since age 3 and still has a need for further therapy. Initially it took a while to get into SALT services, access to SALT was through a referral by the Health Visitor. The first six sessions (*pre-Covid*) were delivered at home. Because there was no Speech and Language Therapist based in the Tywyn area. The Speech and Language Therapist had to drive all the way from Bangor for the hour session. The service was delivered in Welsh.

Mum was given a file with a programme called '*Can I Join You'*. She felt it would have been helpful to have someone there to go through the programme with her and was told there are courses, but not in Tywyn. Additionally there was no network of people in Tywyn to ring to ask for advice.

During lockdown her child received no therapy sessions between March and September 2020 and there was no contact from SALT. Mum says she would have appreciated a phone call to let her know what was going on.

Her child started school in September 2020 and has yet to receive a service in school. Mum is concerned that there seems to be a missing link between the school and the Speech and Language Therapy team, they are not linking up and no one has answers. Her child is now six and is not receiving the help needed.

A new member of the SALT team did contact Mum in September 2020 and seemed shocked that her child had not received therapy in the previous six months. She did apologise for this and said she would pass on Mum's complaint but no-one has addressed this and no response has been received.

Contributions from Education Professionals

We received valuable and insightful contributions from education professionals. A major concern was the huge rise in the number of children needing Speech and Language Therapy input.

Participants made the following comments about the services in the East of the BCUHB region:

- Working in a special school serving 300 children, there has been a huge increase in children needing SALT services.
- The school has an allocated Speech and Language Therapist. The Speech and Language Therapist will come to see children 2 terms out of three only. This can be challenging.
- VC facilities have increased flexibility.
- Parents are frustrated because there is not enough Speech and Language Therapy provision to meet rising need. This will get worse.

We spoke with an education professional working in a primary school in the West of the BCUHB region. This person managed referrals to NHS Speech and Language Therapy.

We were advised that the school uses a pro-forma to refer children to the SALT service in order to give a consistent picture of the child for the SALT team. It was felt that the referral process and form had been working well.

Pre-pandemic the response from SALT was quick and the school were happy with the timescales and the service generally. The lockdown had an effect on the service and the ability of schools to work with the SALT service and problems have continued post-lockdown.

The school is aware that there have been some staffing challenges with the SALT service, resulting in no reports being received on some children or reports arriving but with no targets. There is concern that there are not enough Welsh-speaking Speech and Language Therapists. This is a challenge for the service, which must be acknowledged by BCUHB and by Welsh Government.

Provision of therapy over Teams (VC) has not been easy, especially with very young children. There have been considerable difficulties with sound quality, even though there were no technical problems.

Previously Speech and Language Therapists would visit children at school. The use of Teams within schools has been challenging because a member of school staff is now required to sit with the child throughout the Teams session. This is proving difficult when

schools face their own staff shortages. At times, this results in the cancellation of the session.

Lack of continuity following departure of a Speech and Language Therapist has been a challenge for children who have been receiving therapy.

Schools use IDP (*Individual Development Plans*) on-line for children with additional learning needs. Schools were advised that the NHS should be part of this statutory requirement and that a named person from NHS should be included in the IDP. Recently it has not been possible to name a Speech and Language Therapist and this is a matter of concern.

It was believed that the service met the school's needs pre-pandemic but it is no longer satisfactory. The relationship, understanding and lines of communication are not working in the way they were prior to lockdown.

The lack of face-to-face sessions is leaving a big gap in the service, where does this leave the children in terms of Speech and Language Therapy? Also of concern is that there will be even greater pressure on the service, with the referral of older children who have missed therapy sessions between March and September 2020.

There is an increase in the number of children needing the service. The lockdown has meant that some children have lost a lot of time in school over the past 18 months, which has had an effect.

We were told that education staff find aspects of the BCUHB website very useful. Occupational Therapy is very good with a number of resources available for schools and parents. Schools are able to print off resources to help children. The same cannot be said of the SALT section. There is a list of resources, but you cannot click on the links and print off the resource. It was suggested that this could be developed further and possibly reduce the pressure on the department.

Learning Disability

We met with a member of the Learning Disability Team (Adults) for a North Wales Local Authority. It was their experience that a large proportion of people with challenging behaviour need SALT services. Inability to communicate is one of the biggest causes of challenging behaviour.

We were told that there is one Speech and Language Therapist undertaking the assessments for Adults in the Local Authority area 2 days a week and this time is shared with another county. Due to sickness absence, there have been times when no cover has been available.   This has impacted on behaviour support plans for clients. Such plans are not comprehensive without the communication element and they must be written by a Speech and Language Therapist professional. This is vital when making an application for Continuing Health Care funding. Delay in providing a SALT assessment will cause a delay in receiving Continuing Health Care funding. The information received from the SALT is very helpful, but the delay in receiving the assessment is a major problem. They are currently experiencing delays of six months or more.

They are having young people coming through transition from children's services to adult services without a SALT report/plan. Occasionally clients will have had a SALT assessment but it has been archived, so they will have to start the process from scratch, which causes a backlog. It would be helpful to have more continuity and a structured transfer between the Adult and Children's SALT teams.

Before the pandemic, assessments used to be face to face, but are now by Zoom. This works well for most clients. The Speech and Language Therapists' contributions are highly valued but they are overworked and this is affecting Learning Disability services in the Local Authority area.

We spoke to the mothers of two young people with profound learning disabilities in the West of the BCUHB area. Both children had received Speech and Language Therapy previously but they were struggling to keep SALT input now.

Mum A explained that her child has a particular condition and, although her child is very sociable, the child is non-verbal. Her child is now 20 years old and will never be able to speak or sign, it's part of the syndrome. They had a good relationship with the child's Speech and Language Therapist but Mum does not think the SALT service really knew how to help her child.

Mum B's child is 13yrs old and is also non-verbal, her child is on the Autistic spectrum and has been diagnosed with severe Learning Difficulties and Autism.

Both use technology (*the iPad based AAC system based on pictures*) to help their children communicate but told us that Speech and Language Therapists do not support its use. They both felt that SALT training was not keeping pace with technology and that Speech and Language Therapists are reluctant to try something new.

They suggested that SALT training should focus on technology that gives access to words that children can use and manage.   They told us that in order to be referred for an electronic device to help the child with their communication, the child has to prove that they are able to use the device competently. They believe it would be better to let the child try it and see how they get on with it. Because of the competency requirement, children are not given the opportunity to try using the electronic communication system, which could make a massive difference to their quality of life.

During the period March to September 2020, neither child received any Speech and Language Therapy input. Post-lockdown they are still working with the same targets and the same tools that they were using pre-pandemic.

Both Mums wanted to make it clear that what a Speech and Language Therapist may class as a tiny improvement could be a major improvement in quality of life for the child and their family.

For the older child, the transition to adult services happened when Covid hit. The child is now regarded as an adult and no longer has access to a Speech and Language Therapist. However, the child's needs have not changed and still needs support. Mum was told her child can be re-referred to the service but she does not feel the adult service is geared up for her child's needs. Mum believes that there needs to be a better transition, it has felt like

her child was pushed off a cliff's edge at 18 years old and that it would be better to have the transition into Adult Services phased to 25 years old.

Both Mums felt that the SALT service struggled with complex children like theirs, where there was a great deal of input for what might appear to be relatively small improvements.

Welsh Language

During our discussions with education professionals we were told that they had concerns about the recruitment of Speech and Language Therapists many Welsh-speaking speech therapists have left the service and schools have been advised to review children to see if any could possibly have English therapy provision rather than Welsh. This is a concern, especially in Gwynedd. The lack of Welsh speaking therapists has been raised by constituents with Sian Gwenllian MS and there are plans to lobby at national level.

We met with English-speaking families in Bangor who told us that the special school attended by their children had declined, in the absence of Welsh speaking speech therapists, to allow English-only speech therapy to take place in the school. They felt that this further disadvantaged their children. We heard a dichotomy of views on this issue with some parents supporting such action and others feeling that Speech and Language Therapy in English was better than no Speech and Language Therapy at all.

NWCHC staff advised participants that a new Speech and Language Therapy Course will begin at Glyndwr University and this may improve recruitment in the medium term. The NWCHC has raised the importance of the Welsh language being a key element within this new course with the Welsh Language Commissioner.

We were asked whether there would be an opportunity for qualified teachers to undertake the course in order to become a Speech and Language Therapist.

Plaudits

We heard from a Mum in the East region who has a 12 year old deaf child, now discharged from the SALT service. The child was diagnosed as deaf at 2½ years and had Speech and Language Therapy at home in one to one sessions. The family wanted the child in mainstream school and, with educational support, the child is now an A* pupil.

"*I am very happy with the service received for my 3 year old from* Speech and Language Therapists *based in Dolgellau and Blaenau Ffestiniog. I have seen a great development in my child's language*" (*received in Welsh by email*).

We had an email from a dad in Flintshire. He told us that his child was diagnosed with Verbal Dyspraxia and Velopharyngeal Incompetence (VPI) at seven years old. The child was referred to SALT by a consultant at Alder Hey Hospital. The child received Speech and Language Therapy at school and came on in "*leaps and bounds*" and could pronounce more words. The dad tells us that Speech and Language Therapist, worked with his child for 5 years and delivered amazing results.

The father has nothing but praise for what SALT is doing via the Special Educational Needs (SEN) department at his child's school. He told us that by having the SEN department

based at the school, it helps keep children in main-stream school, and it stops them from being ostracized and isolated from their peers. He believes that having a dedicated SEN department at schools would relieve the pressure on the BCUHB SALT service.

Acknowledgements

We thank the people who took the time to tell us about their experiences and share their ideas.

We hope they influence Betsi Cadwaladr University Health Board to recognise and value what they do well – and make improvements so that the things that cause very real difficulties for people using the NHS are addressed.

Feedback

We want to hear what you think about this publication, and any suggestions about how we could have improved it, so we can use this to make our future work better.

Office contact details

Unit 11 Chestnut Court   Units 1B and 1D Wilkinson Business Park
Ffordd Y Parc   Clywedog Road South
Parc Menai   Wrexham
Bangor   LL13 9AE
LL57 4FH

Telephone: 01248 679 284 or 01978 356178

E-mail: Admin2@wales.nhs.uk

Website: https://gogleddcymrucic.gig.cymru/

Social Media: NorthWalesCHC   NWCHC   NWCHC

Presentation

Gwasanaethau Therapi Lleferydd ac Iaith yng Ngogledd Cymru

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

CIC GOGLEDD CYMRU / NORTH WALES CHC

Digwyddiadau Ymgysylltu â'r Cyhoedd

2021

Speech and Language Therapy Services in North Wales

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

CIC GOGLEDD CYMRU / NORTH WALES CHC

Public Engagement Events

2021

NorthWalesCHC   NWCHC   NWCHC

Croeso

- Diolch i chi gyd am ddod

- Fy enw i yw Geoff Ryall-Harvey, Prif Swyddog Cyngor Iechyd Cymuned Gogledd Cymru (CICGC). Mae hefyd aelodau o staff ac aelodau gwirfoddol y CICGC yma heddiw

Welcome

- Thank you all for attending

- My name is Geoff Ryall-Harvey, Chief Officer of the North Wales Community Health Council (NWCHC). We also have members of NWCHC staff and volunteers here today

NorthWalesCHC   NWCHC   NWCHC

1

Cyflwyniad

- Digwyddiad gwrando ac ymgysylltu yw hwn i sicrhau bod llais y defnyddiwr yn cael ei glywed gan Fwrdd Iechyd Prifysgol Betsi Cadwaladr yn ei adolygiad o Wasanaethau Therapi Lleferydd ac Iaith.

- Rydym yn cynnal cyfres o 20 o ddigwyddiadau wyneb yn wyneb ledled Gogledd Cymru yn ystod mis Medi, Hydref a Thachwedd ynghyd â 3 digwyddiad rhithwir ar-lein.

Introduction

- This is a listening and engagement event to ensure the user voice is heard by the Betsi Cadwaladr University Health Board in its review of Speech and Language Therapy Services

- We are holding a series of 20 face to face events across North Wales during September, October and November together with 3 on-line virtual events.

NorthWalesCHC NWCHC NWCHC

2

PWY YDYM NI

- Cyngor Iechyd Cymuned Gogledd Cymru
- Corff gwarchod iechyd Gogledd Cymru
- Annibynnol a Chyfrinachol
- Yn cynrychioli Profiadau Cleifion o ddefnyddio'r GIG
- Monitro a Craffu ar Wasanaethau Iechyd
- Ymgysylltu â Chleifion
- Gwasanaeth Eiriolaeth Cwynion

WHO ARE WE?

- North Wales Community Health Council
- Health watchdog for North Wales
- Independent and Confidential
- Represents the Patients Experiences of NHS
- Monitors and Scrutinises Health Services
- Patient Engagement
- Complaints Advocacy Service

CICGC - Ein Gweledigaeth

¿ Bydd CICGC yn gweithio i ddatblygu gwasanaethau iechyd sydd yn cael eu dylanwadu gan farn a chyfanogiad cleifion a chyhoedd Gogledd Cymru

    ¿ llais cyhoeddus cryf yn adlewyrchu'r hyn sydd gan bobl i'w ddweud am wasanaethau iechyd

    ¿ cysylltu â'r rhai sy'n cynllunio ac yn darparu gwasanaethau iechyd yng Ngogledd Cymru er mwyn sicrhau eu bod yn croesawu ac yn dysgu o'r adborth a roddir

NWCHC – Our Vision

¿ NWCHC will work to develop health services which are influenced by the views and involvement of the patients and the public of North Wales

    ¿ strong public voice reflecting what people have to say about health services

    ¿ liaise with those who plan and deliver health services in North Wales in order to ensure that they welcome and learn from the feedback given

Beth nad ydym yma i'w wneud

¿ Trafod canmoliaeth, sylwadau, pryderon, cwynion ynghylch gwasanaethau y tu allan i'r Gwasanaethau Therapi Lleferydd ac Iaith yng Ngogledd Cymru

¿ Trafod unrhyw fater arall sy'n gysylltiedig â BIPBC y tu allan i Wasanaethau Therapi Lleferydd ac Iaith yng Ngogledd Cymru

What we are not here to do

¿ Discuss compliments, comments, concerns, complaints regarding services outside of Speech and Language Therapy Services in North Wales

¿ Discuss any other issue associated with BCUHB outside Speech and Language Therapy Services in North Wales

Rheolau Sylfaenol Ground Rules

¿ Parchu barn eraill – efallai nad ydych yn cytuno – ond dyna eu barn!

¿ Respect other participant's views - you might not agree - but it's their view!

¿ Cyfrinachedd – dim recordio, dim nodiadau mewn urnhyw ffurf am stori rhywun arall heblaw am CICGC

¿ Confidentiality - no recording or note taking in any form regarding anyone else's story except by NWCHC

¿ Caniatáu i eraill siarad, bydd pawb yn cael cyfle

¿ Allow others to speak, everyone will get an opportunity

Y Fframwaith   The Framework

¿ Bydd yr holl gyfraniadau yn anhysbys, bydd angen i ni gael manylion cyswllt gan y rhai sy'n cymryd rhan – ond ni fyddant yn cael eu rhannu

¿ All contributions will be anonymised, we would need to take contact details from participants – but these will not be shared

¿ Bydd angen rhannu gwybodaeth pe byddai niwed difrifol neu gamymddwyn troseddol posib yn cael ei ddatgelu

¿ Information would need to be shared in the event of serious harm or potential criminal wrong doing being disclosed

Y Fframwaith ...parhad

¿ Bydd CICGC yn cefnogi unigolion os oes angen cymryd pryderon neu gwynion ymlaen i BIPBC

The Framework ...continued

¿ The NWCHC will support individuals if concerns or complaints need to be taken forward to BCUHB

Heddiw

¿ **C**anmoliaeth, **C**omments (sylwadau), **C**oncerns (pryderon) a **C**hwynion

¿ **C**ynllunio Gofal a **C**hyflawni Gofal

¿ **C**yfathrebu ac ymgysylltu

Today

¿ **C**ompliments, **C**omments, **C**oncerns and **C**omplaints

¿ **C**are Planning and **C**are delivery

¿ **C**ommunication and engagement

CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL

CIC GOGLEDD CYMRU / NORTH WALES CHC

Dewch i ni fwrw iddi!   Lets get started!

Sample of NWCHC Social Media Posts

CIC Gogledd Cymru/North Wales CHC @NWCHC · Aug 18, 2021
Bydd @NWCHC yn cynnal cyfres o ddigwyddiadau i siarad a phobl ynglyn a Gwasanaethau Therapi Iaith a Lleferydd yng Ngogledd Cymru. Rydym eisiau clywed barn a phrofiadau pobol
I gadw eich lle
🌐 svy.at/b7f1g
✉️ yourvoice@waleschc.org.uk
☎️ 01248 679284 (gadael neges)
Show this thread

CIC Gogledd Cymru/North Wales CHC @NWCHC · Aug 31, 2021
⬇️⬇️⬇️

CIC Gogledd Cymru/North Wales CHC @NWCHC · Aug 18, 2021
NWCHC will be holding a series of events to talk to people about Speech and Language Therapy services in North Wales. We want to hear people's opinions and experiences of the service
To book your place:
🌐 svy.at/b7f1g
✉️ yourvoice@waleschc.org.uk
☎️ 01248 679284
Show this thread

CIC Gogledd Cymru/North Wales CHC @NWCHC · Oct 6, 2021
‼️ THERAPI IAITH A LLEFERYDD ‼️
Rydym eisiau clywed am eich profiadau o'r gwasanaeth therapi iaith a lleferydd yng ngogledd Cymru. Cofrestrwch heddiw i fynychu un o'n digwyddiadau.
I gofrestru
🌐 svy.at/b7f1g
✉️ yourvoice@waleschc.org.uk
☎️ 01248 679284

CIC Gogledd Cymru/North Wales CHC @NWCHC · Oct 6, 2021
‼️ SPEECH AND LANGUAGE THERAPY (SaLT) ‼️
We want to hear about your experiences of speech and language therapy (SaLT) services in north Wales. Register today to attend one of our events.
To register:
🌐 svy.at/b7f1g
✉️ yourvoice@waleschc.org.uk
☎️ 01248 679284

**CYNGOR IECHYD CYMUNED
COMMUNITY HEALTH COUNCIL**

N E W S   R E L E A S E

11 AUGUST 2021

HEALTH WATCHDOG ASKS PEOPLE TO DISCUSS SPEECH AND LANGUAGE THERAPY SERVICES

The independent health services watchdog for North Wales – the North Wales Community Health Council (NWCHC) - is keen to hear from people who have experiences of Speech and Language Therapy services in North Wales.

The NWCHC will be hosting a series of face to face events across all six counties of North Wales and via video conference, during September, October and November. Patients, their carers and their families are invited to talk about all aspects of NHS Speech and Language Therapy Services.

The events will take place as follows – with 3 different sessions at each location.

Conwy				
8 September	Llandudno Junction	10.00am	1.30pm	4.00pm
7 October	Colwyn Bay	10.00am	1.30pm	4.00pm
15 October	Betws-y-Coed	10.00am	1.30pm	4.00pm
12 November	Llanfairfechan	10.00am	1.30pm	4.00pm
Denbighshire				
13 October	Rhuddlan	10.00am	1.00pm	3.30pm
1 November	Corwen	10.00am	1.00pm	3.30pm
11 November	Denbigh	10.00am	1.30pm	4.00pm
Flintshire				
29 September	Connah's Quay	10.00am	1.30pm	4.00pm
22 October	Mold	10.00am	1.30pm	4.00pm
17 November	Flint	10.00am	1.30pm	4.00pm
Gwynedd				
7 September	Porthmadog	10.00am	1.30pm	4.00pm
14 October	Ganllwyd	10.00am	1.30pm	4.00pm
8 November	Tywyn	10.00am	1.30pm	4.00pm
18 November	Bangor	10.00am	1.30pm	4.00pm
Wrexham				
1 October	Wrexham	10.00am	1.30pm	4.00pm
5 November	Rhosllanerchrugog	10.00am	1.30pm	4.00pm
9 November	Wrexham	10.00am	1.30pm	4.00pm
Ynys Mon				

6 September	Amlwch	10.00am	1.30pm	4.00pm
19 October	Llangefni	10.00am	1.30pm	4.00pm
25 November	Menai Bridge	10.00am	1.30pm	4.00pm
Virtual Event				
4 October	On-line			6.30pm
11 October	On-line		2.00pm	
20 October	On-line	10.00am		

Mr Geoff Ryall-Harvey, Chief Officer for NWCHC said "*We have worked alongside the BCUHB Speech and Language Therapy Services to make sure that people have a say in the way that the services are developed in North Wales. Our engagement events will take place in a number of locations across the region, providing an opportunity for people to tell us about their experiences of the services. It is vital that we present the feedback and suggestions of all those who use Speech and Language Therapy services to those who make decisions and policies*"

Mr Ryall-Harvey went on to say "*The events will be structured around a number of aspects such as compliments, concerns and complaints, care planning, care provision and communication. We understand that in some instances, people might wish to share experiences in a more confidential way and we will ensure that there is an opportunity for such discussions to take place privately*".

Should you wish to attend any of the events or for further information please contact the North Wales Community Health Council on tel: 01248 679284 (*nb there is an answerphone system in operation – please leave a message and a member of our team will be in touch*) or e-mail yourvoice@wales.nhs.uk

You can also register your attendance via our SurveyMe app by using the following link:

https://svy.at/b7f1g

NB Registration is on a first come, first served basis but we will put on additional sessions as necessary

When booking, please advise whether you would wish to contribute to the discussions through the medium of Welsh or English. Please also advise of any requirements in relation to communication or access.

Note for editors

1   North Wales Community Health Council (CHC) is an independent statutory organisation which represents the interests of patients and the public in the National Health Service in North Wales. It came into being on 1 April 2010 as part of the reorganization of health services in Wales and covers the counties of Conwy, Denbighshire, Flintshire, Gwynedd, Wrexham and Ynys Môn. The six counties have a combined population of around 675,500.

2   The Community Health Council has six local committees, one covering each of the six counties. Each local committee comprises members drawn from three sources: councillors nominated by the relevant local authority, people nominated by the local voluntary sector organizations and local people appointed by Welsh Assembly Government.

ends

North Wales Community Council - Contact details

Post: Unedau 1B & 1D, Parc Busnes Units 1B & 1D, Wilkinson Business
       Wilkinson, Ffordd De Clywedog, Park, Clywedog Road South,
       Ystad Ddiwydiannol Wrecsam, Wrexham Industrial Estate,
       Wrecsam. LL13 9AE Wrexham. LL13 9AE

       11 Llys Castan, Ffordd y Parc, 11, Chestnut Court, Parc Menai,
       Bangor, Gwynedd. LL57 4FH Bangor, Gwynedd. LL57 4FH

Telephone: 01248 679 284 or 01978 356178

E-mail: Admin2@wales.nhs.uk
Website: https://gogleddcymrucic.gig.cymru/

Social Media: NorthWalesCHC NWCHC NWCHC

BCUHB Speech and Language Therapy   Service Recovery Plan On A Page 2022

Current Status →	Planned Activities →	Metrics/KPIs →	Outcomes →

Stakeholder Communication and Feedback

Current Status

CIVICA feedback system live in East Therapies, not West/Centre
Compliments/Complaints logged on DATIX/PALS team across BCUHB
BCUHB Website includes SLT service page: limited self-management information currently available.
Historic Intranet pages include legacy SLT service pages
Extensive engagement exercise with NWCHC Autumn 2021 – yielding 25 respondents only, representing only 0.003% of SLT caseload.
Regular Area-based meetings with key partners in each Local Authority (LA)

Planned Activities

CIVICA roll-out across West/Centre Therapies aimed to achieve more patient feedback.
SLT engagement with CIVICA project team – Q1 2022-23 to support system's accessibility.
BCUHB Website SLT service pages to be developed Q2 2022-23.
BetsiNet SLT service pages to be launched Q1 2022-23
Termly SLT service updates to be published and shared directly with all Local Authorities by Summer school term 2022
Local LA partnership meetings to be retained

Metrics/KPIs

RealTime survey link on all staff email signatures and patient discharge reports.
East/West/Centre SLT service registered with CIVICA system and receiving weekly feedback reports by Q3 2022-23.
Website/BetsiNet pages fully operational by Q3 2022-23.
SLT Compliments/Complaints reported on Therapies Balanced Scorecard.
SLT Compliments/Complaints reviewed/analysed in Area as part of Head of Service minuted accountability meetings.
Termly Local Authority Updates to be archived and minuted in Area SLT leadership group records.

Outcomes

Regular feedback is received from patients and stakeholders
Qualitative feedback received is routinely used to support service continual improvement – evidenced through leadership group minutes in each Area.
Up to date service information is directly accessible to patients and service users.

Workforce Recruitment and Retention

Current Status

SLT is a recognised shortage profession.
Locums in short supply, generally limited to remote working, based outside Wales.
However, SLT vacancy rates below BCUHB and Therapies averages since March 2020, except in West Area from July 2021 onwards.
Staff with Welsh language competency currently reflects local population levels in all 3 Areas (Census data 2011).
Wrexham Glyndwr Uni (WGU) SLT course commences Sept 22; Cardiff Met Uni (CMU) currently only Welsh HEI with SLT course.
Staff Wellbeing Champions in East/Centre SLT teams.
Service gaps are appropriately risk assessed.

Planned Activities

BCUHB engaged in Streamlining process with HEIW.
Joint working with WGU to develop local course and feed-through for placements and future jobs.
Continual workforce planning to increase support worker roles where safe, effective and affordable where qualified SLTs are not available.
Continual workforce planning to support retention – flexible working, skill and role development, compassionate leadership
West area developing Staff Wellbeing Champions

Metrics/KPIs

Number of business continuity risk assessments recorded (DATIX/service records)
Number of staff recruited to BCUHB through streamlining each year (HEIW reporting)
Number of SLTs recruited from WGU from 2025 onwards (service tracking)
Vacancy rate within SLT compared to Therapies/BCUHB averages. (ESR)
Sickness absence rate within SLT compared to Therapies/BCUHB averages. (ESR)
Workforce Welsh competency data (ESR)
Data from staff exit interviews to support future recruitment/retention.
Number of locums recruited across SLT (ESR)

Outcomes

Innovative workforce plans in place (will include agreed managed financial risks to support succession planning)
Clinical risks mitigated as far as possible.
Steady throughput of students from WGU in BCUHB on placement (from 2023). Steady throughput of WGU graduates recruited (via streamlining) from 2025.
Ongoing recruitment from HEIs outside of Wales outside of streamlining process.
Vacancy rate within SLT will be in line with BCUHB average.
SLT workforce language competency will continue to reflect the local population demographics.

Waiting times for Assessment and Intervention

Current Status

Reported <14 week wait time for initial assessment has been largely achieved in SLT throughout the pandemic, resulting in disproportionately long follow-up waits impacting on paediatric caseloads.
Follow-up waits in Therapies not reported on Balanced Scorecard.
Longest wait between appointments in paediatric SLT: 123 weeks (as at 26/4/2022)
Therapy Manager system not capable of recording 'planned waits' – manual data analysis required. No published data to compare across therapy services.
Tele-health available across SLT where clinically appropriate.

Planned Activities

Validation of all caseloads following Covid service restriction. Manual audit required in each clinical team in all Areas of BCUHB SLT.
Planned longer initial wait times to divert some clinical time to follow-up list management. Expectation of <20 weeks initial wait times to be reported, until end March 2023.
Continued use of tele-health to support service efficiency wherever clinically appropriate.
Continual development of BCUHB Website and Helplines to support patients to 'wait well' given known longer wait times.

Metrics/KPIs

All SLT follow-up lists will be clinically validated by end-September 2022 – minuted LMG meetings in Areas.
Manual quarterly follow-up caseload audit in Area teams to be reported to AADs in SLT accountability meetings (minuted).
SLT breaches of 14 week initial wait times to be reported as per Therapies balanced scorecard.
Activity levels and breakdown - balanced scorecard.

Outcomes

All patients on SLT caseload will have a known future action and timeframe.
No child will have waited longer than 52 weeks between SLT appointments by end March 2023. (52 weeks being the maximum planned wait within any SLT clinical pathway of care).
SLT service operates an embedded 'blended' delivery approach, including tele-health and direct patient contact.
SLT service operates live Website which supports patients and stakeholders with up to date information to 'wait well'.
Paediatric Helplines in all Area teams are available and publicised.

Report title:	Interim standard operation procedure – Inpatient Discharge		
Report to:	Quality and Safety Executive		
Date of Meeting:	5 July 2022	Agenda Item number:	2.2 QS22/118
Executive Summary:	The current Discharge Policy and Protocol (NU01) is beyond its date for review. Whilst this policy is robustly reviewed and repurposed to reflect current best practice and guidelines, an interim Standard Operating Procedure (SOP) has been developed. It is intended that this will be consulted on and adopted in all inpatient settings across BCUHB. The SOP is designed to promote safe and supportive discharge for all patient and embedded in home first principles. The aim of the SOP is clearly define the process for discharge and support the individuals involved in discharge to clearly understand their role and responsibilities.		
Recommendations:	The Board is asked to: Note the SOP in draft and approve in principle.		
Executive Lead:	Gaynor Thomason, Interim Executive Director of Nursing and Midwifery		
Report Author:	Naomi Holder, Site Director of Nursing, East Secondary Care Jayne Sankey, Interim Area Nurse Director, East Area		

Purpose of report:	For Noting ☐	For Decision ☒	For Assurance ☒

Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Link to Strategic Objective(s):	
Regulatory and legal implications	
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Financial implications as a result of implementing the recommendations	Nil of significance
Workforce implications as a result of implementing the recommendations	No adverse impact anticipated
Feedback, response, and follow up summary following consultation	Consultation phase to be undertaken
Links to BAF risks:	

(or links to the Corporate Risk Register)	
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:
Rapid consultation with key stakeholders
Launch of SOP
Development of final version of Discharge policy (NU01)

List of Appendices:
Draft SOP - Discharge Procedures using Home First Principles

Date Created:	June 2022	**Standard Operations Document**
Creator:	N Holder/J Sankey	Discharge Procedures using Home First Principles
Version:	V1.0	
Review Date:	June 2023	Covering:
		All inpatients, BCUHB

| **Purpose:** | The following admission referral process **Standard Operating Procedure (SOP)** has been created to ensure:

The purpose of this SOP is to set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for all patients. It aims to fully involve patients and their carers/relatives in the discharge process and ensure that patients receive appropriate assessment, planning and information about their discharge and after care.

Patient discharge must be seen as an interdisciplinary and/or multidisciplinary issue. Therefore, this policy applies to all permanent, locum, agency and bank staff of BCUHB, including doctors, nurses, allied health professionals, social care professionals and managers.

Whilst the SOP outlines how BCUHB will manage effective discharge implementation it does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance. | | |
| --- | --- | --- | --- |
| **Endorsed by:** | Nurse Lead | Name:

Signature: | |
| | Operations Lead | Name:

Signature: | |

Contents

1. INTRODUCTION

Betsi Cadwaladr University Health Board recognises that to facilitate safe and smooth discharges from care in hospital to care in the community, an alternative care provider or a person's own home, the discharge plan must be well defined, prepared and agreed with each individual patient. To allow sufficient time for suitable and safe arrangements to be made, discharge planning should begin on admission, or at pre-admission clinics, with an expected date of discharge (EDD) being identified within 48 hours of admission and communicated to patients and, if appropriate, their carers/relatives. This puts emphasis on an early 'What Matters to Me' conversation being facilitated at an early time by the right person to understand our patients, what matters to them and this will influence what we do and to which discharge pathway they will be allocated.

This standard operating procedure (SOP) identifies the roles of those involved in the discharge of patients and guides the reader through the processes of discharge. It has long been recognised that collaborative working and good communication between agencies are key in ensuring that people needing care have the supporting services they need at home or elsewhere.

The aim of this SOP is to ensure that all agencies involved in the provision of social, nursing or medical care work together to deliver an effective, smoothly coordinated service that meets the needs of it users, patients, carers and families.

This SOP applies to individuals (and their representatives) who have finished their treatment, are fit for discharge and are safe to transfer (as per the Care Act 2014 definition).

Over-riding principles include:

Right patient, right place, right care.
Home first (wherever possible).
Person - centred and a maximising independence approach.
Releasing time to care.
Reduced duplication of assessment through Trusted Assessor/Professional.
Incorporating 'What Matters to Me'

2. DEFINITIONS

Patient Discharge Pathways

The Health Economy Home First Team will work with the Multi-Disciplinary Team (MDT) ward staff to identify patients suitable on wards for the pathways:

Pathway 0

Patients who can be safely discharged without formal support.

Pathway 1

Patients whose admission can be avoided by person-centered multidisciplinary assessment within the Emergency Department or within the community setting. Patients can access treatment a supported recovery at home if clinically safe to do so.

Pathway 2

Patients who can be supported home from the acute setting once medical treatment that requires an inpatient stay is completed. This includes supporting patients to recover at home and reassessing after this period to determine ongoing needs.

Pathway 3

Patients who are unable to go home once medical treatment has been completed and who may benefit from recovery or rehabilitation time or require further assessment out of the acute hospital setting.

Pathway 4

Highly complex patients who at present appear to have no immediate reablement/rehabilitation needs but who have probable long term care needs and need further out of hospital assessment, still benefiting from a maximizing independence approach to care

3. Expected Date of Discharge (EDD):

A target discharge date to which all agencies can work whilst recognising that the date may change according to the patient's needs/clinical status. An EDD should be set at the first Consultant review and no later than the first Consultant post take ward round the next morning. This should represent a professional judgement of when a patient is anticipated to achieve their clinical and functional goals and can leave hospital to recover or rehabilitate in a non-acute setting (usually their normal place of residence).

Patient progress towards EDD should be assessed every day at a board or ward round led by a senior clinical decision maker (normally the consultant).

4. Managing the Discharge of Patients with Complex Needs (Pathway 2, 3 & 4):

The health professional coordinating the discharge must ensure all points relating to discharging patients with complex needs have been considered, as follows:

The Complex Discharge Team based within Home First Team will normally be involved in the discharge of patients with complex nursing needs and can provide expert advice to ward/ staff and department managers to:

- Assist ward staff in the identification of patients with ongoing care needs.
- Support ward staff in assessment of patient discharge needs and assist ward staff in making alternative discharge plans, as appropriate
- Inform ward staff about eligibility and process for accessing Continuing Health Care funding
- Provide an ongoing programme of education around CHC matters for ward/department staff.

The patient and, where applicable, the home carer (including informal carers) must be central to the discharge plan. They must be kept informed of progress on a regular basis by all members of the multidisciplinary team (MDT). Where appropriate the patient and carers will be invited to attend multidisciplinary meetings, discharge planning and case conferences.

Any concerns regarding a patient with mental health needs or learning disabilities must be taken into account and the discharge planning process must involve the appropriate specialists, to ensure the discharge is appropriate and that the patient is discharged to the right environment for their safety and on-going care needs.

If the patient has been deemed not to have capacity following a capacity assessment (refer to the Mental Capacity Act 2005 or Consent policy) to consider the appropriate advocates available e.g IMCA should be considered before making any discharge plans.

When patients are transferred to a community hospital/ care home the nurse in charge of discharge must ensure:

- Copies of all patient notes including the drug chart are sent with the patient if they are being transferred to a Community Hospital or photocopied notes if they are being transferred to a hospital out of area. Care homes should not receive medical notes.
- The doctor caring for the patient must complete an Electronic Discharge Summary and document in the notes that the patient is fit for discharge.
- The nurse in charge of discharge should complete and send a nursing transfer letter.

- The community hospital or care home should be contacted and be given a full handover prior to discharge.
- Transport should be arranged at the earliest opportunity.

Staff must ensure that information about infections and any particular care needs related to those infections and their control are communicated when a patient moves to the care of another organisation, e.g. community nurse, GP, nursing home or community hospital. This information should include:

5. NHS Continuing Health Care (CHC) and NHS funded nursing care:

NHS Continuing Health Care is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospital who have ongoing health care needs. This can be received in any setting, including the patients own home or in a care home. Funding eligibility will need to be determined for all patients with complex health care needs on discharge for all patients. 'NHS-funded nursing care' is the funding provided by the NHS for those patients requiring a 24 hour overview of a registered nurse.

The patients informed consent should be obtained before the start of the assessment process for this. If there is a concern that the individual may not have capacity to give consent, this should be determined in accordance with the Mental Capacity Act 2005.

The consideration for eligibility for continuing healthcare and NHS funded care needs to form part of the discharge planning in line with requirements in the CHC National Framework (April 2022). It is essential that patients, their families and/or carers are fully engaged throughout the process according to best practice as stated in CHC National Framework.

The first step for most individuals is the Checklist Tool. This is a screening tool to help health and social care staff judge whether it is appropriate to undertake a full assessment for NHS Continuing Health Care. If a Checklist has been completed and indicates there is a need to carry out a full assessment of eligibility for NHS continuing healthcare then it will move to an assessment using the 'Decision Support Tool' (DST).

The Decision Support Tool looks at eleven different types of need, for example, mobility, nutrition, and behaviour. The purpose of the tool is to help decide on the nature, complexity, intensity and unpredictability of needs. This process is completed outside of a hospital setting. The care coordinator for this cohort of patients will be the discharge support nurse, however all MDT members including ward staff have a responsibility to join a patient related discharge meeting.

6. Criteria Led Discharge

All patients should be considered for criteria led discharge. Criteria led discharge is undertaken by an appropriately trained Health Care Professional, who will discharge a patient once a senior doctor has designated them to be medically fit when certain criteria are fulfilled.

7. End of Life:

This applies to patients with specialist palliative care needs, however input may be from a single or multi-disciplinary team depending upon the place of discharge.

Where the patient's condition is rapidly deteriorating, the responsible clinician for the patient can use Fast Track Process. This is aimed at individuals who have a rapidly deteriorating condition and may be entering the terminal phase. This assessment will provide the information which will obtain CHC funding as quickly as possible.

The Discharge Support Team will oversee this process.

8. To Take Out Medicines (TTOs):

These are medicines, which the patients take away when they leave hospital. These should be prescribed as early as possible to prevent any delay in discharge.

9. Transport

Where ever possible transport should be booked in advance of the arranged discharge. Ward staff should always explore any other means of transport to reduce waits for transport for those requiring and to improve hospital flow.

10. Discharge Lounge:

The Discharge Lounge is a none-ward environment, which accommodates patients prior to leaving hospital, where care needs can be completed and any communications regarding discharge can be actioned. All patients being discharged home must be considered for transfer to the Discharge Lounge in line with local Criteria.

11. Self-discharge:

This relates to patients wishing to self-discharge against medical advice. Patients with capacity can choose to self-discharge and leave the hospital. If it is felt that a patient lacks

capacity and/or is under Deprivation Of Liberty Safeguards, then staff will need to consult the Deprivation of Liberty Safeguards Policy.

12.DUTIES AND RESPONSIBILITIES

It is anticipated that everyone will work within the SAFER principles when planning and managing discharge. These can be viewed in Appendix A. However, each staff group will hold their own responsibilities in order to support the patients discharge.
It is also anticipated that Discharge Planning commences as soon as the patient is admitted to hospital. Admitting areas will ascertain what the patient's current circumstances are and what may be required to go home. They have responsibility for providing patients with the 'Help Me Home' Leaflet and initiating the 'What Matters to me' conversation

Home First Team will:

- Provide specialist advice and support to wards and the multidisciplinary team on complex hospital discharges.
- Provide informal and formal teaching and education packages to members of the multidisciplinary team on current issues relating to discharge planning.
- Facilitate the CHC Fast Track discharge process ensuring that patients, who have been identified by a hospital clinician as being in a terminal phase with a rapidly deteriorating condition, an increased dependency and who have expressed a desire to die at home, are processed immediately and given a facilitated discharge involving
- Facilitate the Checklist process.
- Coordinating, monitoring and ensuring patients are discharged from BCU safely and, as far as possible, in line with EDD when on a discharge pathway.
- Providing specialist advice and support, signposting to other specialist services. Providing ward links who will act as a point of contact for colleagues within community hospitals, primary care and voluntary agencies in relation to people with complex discharge packages or concerns related to the hospitals discharge procedure and process.
- Facilitating and supporting staff with discharge planning of all patients.
- Monitoring progress and advise on the discharge process including identifying and reporting the reasons for any delayed discharges.
- Hold daily MDT's with Progress Chasers, therapists, Local Authority, CHC and third sector services to ensure patients are assigned and progress along their discharge pathway.
- Draw patients into their service and case manage to achieve a safe and timely discharge from the acute setting into their services.

- Provide specialist screening of patients to ensure that they achieve safe and timely discharges home when on Pathway 2.
- Ensure presence 7 days per week within ED (Nurses and Therapists) to provide assessments to avoid a full hospital admission.
- Facilitate and co-ordinate safe patients transfers to community hospitals.

Progress Chasers will:

- Support the ward with all discharge processes within the scope of their competencies.
- Escalate any blocks affecting patient's discharges and flow appropriately.
- Provide a link between the ward and Home First
- Liaise with the ward nurses and the wider MDT, including Local Authority, to facilitate the discharge

Medical Staff

The Consultant or other appropriate doctor with delegated authority has responsibility for:

- Working within SAFER principles to manage and facilitate discharge
- Determining an EDD that is communicated to the patient, relatives/carer on admission and recorded in the patient's notes
- All patients to have an EDD based on medical and functional suitability for discharge
- Daily Senior Decision Maker review of patients at Board Rounds with Red2Green actions set for each day and checked for completion in the afternoon.
- Ward rounds to follow process of reviewing the sickest patients first, followed by potential patients for discharge today, followed by new patients and finally the ward round of remaining patients.
- Confirming the EDD on the first senior clinical review and ensuring that date is communicated to the multi-disciplinary team (MDT), the patient and their relatives.
- Keeping the patients/relatives/carers fully informed of their progress and treatment in order to progress assessment needs.
- Identify patients suitable for criteria led discharge.
- Completing Discharge Summaries on EPOC
- Liaising with the MDT on a regular basis to enable co-ordination of the agreed discharge date.
- Ensuring any change in the patient's EDD is communicated to the MDT/patients/relatives in the medical notes without delay.
- Ensuring all TTO medication is prescribed at least 24 hours before discharge

wherever possible.

- Ensuring for all patients being discharge under the Fast Track process, have timely written prescription forms are completed to include, anticipatory medications, syringe driver charts if required.

Ward Manager/Senior Nurse /Nurse in Charge has overall responsibility for:

- Ensuring every patient has a copy of the Discharge Letter.
- Ensuring the Discharge Checklist is completed
- All information relating to the discharge is recorded in the patients MDT notes.
- Ensuring that systems are in place so that patient discharge is co-ordinated and progresses according to plan.
- Jointly work with the Senior Decision Maker to ensure review of patients at daily Board Rounds with actions set through Red2Green process and followed up to confirm completion in the afternoon
- Ensuring that information required to plan and manage patient discharges is gathered, and recorded accurately, especially in respect of conversations with the patient, their family and/or carers: including the date and times of those conversations
- Continuously monitoring the discharge progress of all patients, ensure positive action is taken to expedite discharges for those who are fit to leave an acute bed and have exceeded their EDD.
- Ensure all relevant staff are competent to enact the criteria led discharge policy.
- Ensuring that the correct discharge pathways are identified for the patient.

Ward Nurse/Named Nurse is responsible for:

- Discharge planning commences within 24 hours of admission and that progress is appropriate to achieve the EDD.
- All patients receive the 'Help Me Home' leaflet.
- The 'What Matters to Me' conversation.
- The patient and relatives/carers (if appropriate) are involved with all aspects of the discharge planning process, their needs and wishes are taken into account and they have at least 24 hours notices of the discharge date, whenever possible.
- In the absence of the Senior Nurse /Nurse in Charge jointly work with the MDT Decision Maker to ensure review of patients at daily Board Rounds and later in the day follow up of actions as guided by the Red2Green process.
- Complete the criteria led discharge process for suitable patients.
- Escalation to the Home First Bureau for any blocks to patient flow on any discharge pathway.
- The patient's medication is ordered 24 hours before the discharge wherever possible.
- Appropriate transport arrangements are made and that all pertinent information regarding the patient's condition is given to the ambulance service transporting

patients. (E.g. Do Not Attempt Resuscitation [DNAR] status, infections, issues regarding transferring/manual handling). When arranging transport for discharge it is vital that the discharge address including Post Code is confirmed and checked as correct, as it may differ to the patient's home address. It is equally important to check that the patient can access their destination address e.g. do they have a key, can they manage any steps at the property.

- Transport for bariatric patients and for property that is difficult to access must be booked 48hrs prior to discharge.
- Transport should only be provided for discharge when the patient is not safe to use own transport and family or friends are unable to assist. Transport can be booked 24/7 via the on line booking service and all staff should access this system to book accordingly to the patient's needs and mobility status. Transport can be booked over the telephone during working hours only.
- The receiving hospital, care home or social care facility (or community nurse team, if the patient is returning home) is notified of any known infection and the current infection control practices in place e.g. antibiotic therapy, dressing regime, barrier nursing.
- The patient has the necessary medication, dressings and relevant information about post discharge care.
- All arrangements and referrals in relation to discharge planning are clearly documented, signed and dated within the discharge planning documentation.
- All healthcare professionals involved with the patient are notified of any change in the patient's ward placement and or condition/suitability for discharge with a request for a review as appropriate.
- Any potential delays in discharge are referred immediately to the Home First Team as soon as they become known outlining the reasons for the delay or potential delay.
- All necessary information for discharge/transfer of care and management is gathered, recorded and communicated appropriately.
- Completion of the Discharge Checklist within the All Wales Nursing Assessment Document
- Pre noon discharges should be aimed for in all cases.
- Use of the Discharge Lounge is to be considered for every patient being discharged.

Pharmacy

- Ward Pharmacist to be informed of any changes immediately, and patients with NOMADs to be identified earlier if possible
- Ensuring all TTO medication is dispensed at least 24hrs before discharge (where possible).
- Patients transferring under Fast track Process should have anticipatory medications written and dispensed accordingly.
- Recognising the Electronic Discharge Summary should be completed if unable due to IT breakdown then a hand written version should be legible on all copies provided.

13.TRAINING

The Health Economy Home First Team, along with external providers, delivers education for ward/department staff in relation to discharging with Continuing Health Care – systems and processes and the Home First Model of Care

The Ward Links will also assist the ward staff in identifying pathways and deliver education relating to this during this process.

APPENDIX A
SAFER

S - Senior Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have an Expected Discharge Date and Clinical Criteria for Discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.

F - Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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

For:	Discharge Procedures using Home First Principles
Date form completed:	Wednesday 29th June 2022

PARTS A: SCREENING and B: KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A   Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Discharge Procedures using Home First Principles
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The purpose of this SOP is to set out the process requirements and staff responsibilities to support well-organised, safe and timely discharge for all patients. It aims to fully involve patients and their carers/relatives in the discharge process and ensure that patients receive appropriate assessment, planning and information about their discharge and after care.

Patient discharge must be seen as an interdisciplinary and/or multidisciplinary issue. Therefore, this policy applies to all permanent, locum, agency and bank staff of BCUHB, including doctors, nurses, allied health professionals, social care professionals and managers.

Whilst the SOP outlines how BCUHB will manage effective discharge implementation it does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance.

Betsi Cadwaladr University Health Board recognises that to facilitate safe and smooth discharges from care in hospital to care in the community, an alternative care provider or a person's own home, the discharge plan must be well defined, prepared and agreed with each individual patient. To allow sufficient time for suitable and safe arrangements to be made, discharge planning should begin on admission, or at pre-admission clinics, with an expected date of discharge (EDD) being identified within 48 hours of admission and communicated to patients and, if appropriate, their carers/relatives. This puts emphasis on an early 'What Matters to Me' conversation being facilitated at an early time by the right person to understand our patients, what matters to them and this will influence what we do and to which discharge pathway they will be allocated.

This standard operating procedure (SOP) identifies the roles of those involved in the discharge of patients and guides the reader through the processes of discharge. It has long been recognised that collaborative working and good communication between agencies are key in ensuring that people needing care have the supporting services they need at home or elsewhere. |

Part A   Form 1: Preparation

Please answer all questions

		The aim of this SOP is to ensure that all agencies involved in the provision of social, nursing or medical care work together to deliver an effective, smoothly coordinated service that meets the needs of it users, patients, carers and families. This SOP applies to individuals (and their representatives) who have finished their treatment, are fit for discharge and are safe to transfer (as per the Care Act 2014 definition).
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	As per the Policies' on policies approval guidance, initial approval will be via the Area East Quality and Safety committee but final approval will be via the Quality and Safety Executive Committee
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	The existing Discharge Procedures using Home First Principles SOP will have been subject to Equality Impact Assessment. This was not able to be located and as the current NU06 has been reviewed and updated a new Equality Impact Assessment has been completed. Other policies that are related to and influenced by Discharge Procedures using Home First Principles are: • BCUHB Policy for Using Bed Rails Safely and Effectively MD07; • BCUHB Guideline for the Management of Delirium for Adults ≥18 years in acute care and long term care settings MM17; • BCUHB Concerns Policy PTR01a; • BCUHB Guidelines for Adult Patients Requiring Enhanced Observation and Engagement within Acute and Community Hospitals; • Dementia Care pathway; • NICE National Institute for Health & Care Excellence Falls in Older People Quality Standard Published 25 March 2015; • Safeguarding Policy. • Right patient, right place, right care. • Home first (wherever possible). • Person - centred and a maximising independence approach.

Part A   Form 1: Preparation

Please answer all questions

		• Releasing time to care. • Reduced duplication of assessment through Trusted Assessor/Professional. • Incorporating 'What Matters to Me'
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The aim of this SOP is to ensure that all agencies involved in the provision of social, nursing or medical care work together to deliver an effective, smoothly coordinated service that meets the needs of it users, patients, carers and families. This SOP applies to individuals (and their representatives) who have finished their treatment, are fit for discharge and are safe to transfer (as per the Care Act 2014 definition). Therefore: • Patients • Next of kin • Families • Carers • Local Authority inc Social Services and Safeguarding • Continuing Health Care (CHC) • Acute Hospital healthcare professionals • Community Medicine healthcare professionals • Third Party providers such as care homes and independent care providers
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Lack of engagement from staff with the training. Lack of time for staff to access level 1 training on ESR and level 2 for clinical staff face to face training 2 yearly as part of manual handling update.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	**Patient Discharge Pathways** The Health Economy Home First Team will work with the Multi-Disciplinary Team (MDT) ward staff to identify patients suitable on wards for the pathways: Pathway 0 Patients who can be safely discharged without formal support.

Part A

Form 1: Preparation

	### Pathway 1 Patients whose admission can be avoided by person-centered multidisciplinary assessment within the Emergency Department or within the community setting. Patients can access treatment a supported recovery at home if clinically safe to do so. ### Pathway 2 Patients who can be supported home from the acute setting once medical treatment that requires an inpatient stay is completed. This includes supporting patients to recover at home and reassessing after this period to determine ongoing needs. ### Pathway 3 Patients who are unable to go home once medical treatment has been completed and who may benefit from recovery or rehabilitation time or require further assessment out of the acute hospital setting. ### Pathway 4 Highly complex patients who at present appear to have no immediate Reablement/rehabilitation needs but who have probable long term care needs and need further out of hospital assessment, still benefiting from a maximizing independence approach to care. A target discharge date to which all agencies can work whilst recognising that the date may change according to the patient's needs/clinical status. An EDD should be set at the first Consultant review and no later than the first Consultant post take ward round the next morning. This should represent a professional judgement of when a patient is anticipated to achieve their clinical and functional goals and can leave hospital to recover or rehabilitate in a non-acute setting (usually their normal place of residence).

Part A

Form 1: Preparation

		Patient progress towards EDD should be assessed every day at a board or ward round led by a senior clinical decision maker (normally the consultant).

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

Please answer all questions

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

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

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

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

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

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

Please answer all questions

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

Part A

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

					NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. For the definitions of each characteristic please click here	
	Yes	**No**	**(+ve)**	**(-ve)**		
Age		NO			Discharge Procedures using Home First Principles is specific to all Adult in patients and will have a positive impact on their experience as it is evidence based interventions and assessment to maintain patient safety. Evidence base includes NICE Quality Standards.	Not applicable
Disability	Yes		Yes		Discharge Procedures using Home First Principles will have no negative impact on inpatients with a disability however; the policy outlines the clear completion of the risk assessment tool that **MUST** be completed on admission for all adult in patients. This has specific consideration for assessment and intervention for Adult in patients with sensory deficit, mobility and cognitive related conditions whilst promoting the individuals level of independence.	Not applicable.
Gender Reassignment		NO			There is no negative impact identified for staff or patients in terms of Gender reassignment. The Discharge Procedures using Home First Principles has been updated using gender neutral language. The policy references only once gender specific term as women on the maternity unit following Caesarean Section.	Not applicable

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

Please answer all questions

Pregnancy and maternity		NO			No negative impact on pregnancy or maternity, Discharge Procedures using Home First Principles	. Not applicable
Race		NO			There is no negative impact on race. Language used in the policy is neutral.	Not applicable
Religion, belief and non-belief		NO			This policy has no negative impact on staff or patients from any faith community, non-belief background. The policy does not impact any rituals or philosophical beliefs. Staff are able to maintain their staff uniform in line with BCUHB uniform guidance when complying with this policy.	Not applicable
Sex		NO			The assessment is that there is insufficient evidence to determine that this policy has a negative impact upon staff or patients in terms of being male or female. The evidence used for this policy development references Older people as opposed to male or female.	Not applicable
Sexual orientation		NO			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to patient sexual orientation.	Not applicable
Marriage and civil Partnership (Marital status)		NO			The assessment is that there is insufficient research, and no evidence of implications or negative impacts related to a patient's marital status.	Not applicable

Part A

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

Socio Economic Disadvantage		NO			This policy will not negatively impact individuals following assessment using the Socio Economic Duty criteria/guidance.	. Not applicable

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

Please answer all questions
Human Rights:

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

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	**No**	**(+ve)**	**(-ve)**			
Yes		Yes		Article 8 UN convention on the rights of people with disabilities	The policy applies equally to all patients with an emphasis on assessment and planning discharge in accordance with article 8 of the Human Rights Act 1998. The policy also considers in more detail the rights of people (Adults) with disabilities for preventing and managing their risk of falls whilst as an in-patient within BCUHB.	Not Applicable

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

Please answer all questions

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	Yes		Yes		Once approved, this policy will be submitted for translation, all posters or checklists for staff will be translated. All public / patients information leaflets are available in the welsh language.	No negative impact identified
Treating the Welsh language no less favourably than the English language		No			Once approved this policy will be submitted for translation.	No negative impact identified

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click* here training vid p13-18)	A full consultation was done with the MDT Steering group. Policy review and development group was full MDT including H & S colleagues. First draft of the policy shared via the consultation portal between 28.06.21 to 28.07.21. Feedback to be received on both the policy and the EqIA as the documents progresses through the approval groups with multi-disciplinary representation.
Have any themes emerged? Describe them here.	Consideration for Women on maternity following childbirth, elective, urgent or emergency surgery. Review and access to staff training.
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	Additional narrative referencing the BCUHB Integrated Care Pathway (ICP) For women requiring an Emergency Caesarean section and women requiring a Planed Caesarean section. Development of robust training package clearly outlined for all BCUHB staff, levels of training reflect the level of clinical responsibility for Adult in patients.

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) for further direction on how to complete this section please click _here training vid p13-18)_	_Copy from Form 1_ Discharge Procedures using Home First Principles

2. Brief Aims and Objectives: (Copy from Form 1)	Betsi Cadwaladr University Health Board (BCUHB) has reported a decreased overall discharge profile and as such it is timely to ensure the necessary safeguards are in place and being carried out to maximise the number of potential discharges under pathway 1-4. This Discharge Procedures using Home First Principlespolicy describes the discharge potential risk assessment and management of all adult in-patients admitted to BCUHB. The risk assessment, identified risks and the evidence based interventions and care planning that are to be used to deliver safe and effective care and discharge by maintaining a safe onward care environment and effective management of care and safe discharge principals. The policy and the appendices contained within it have been assessed in terms of the potential negative impact the policy and the appendices may have on equality of our Adult In patients.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes		No	x

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes		No	x
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes	x	No	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes [ ] No [x]	
	The assessment of the policy and the appendices has not identified any negative impacts in terms of equality. The policy has a positive impact on care of our patients in terms of prevention and management of falls with Adult in patients with a sensory deficit, mobility or cognitive conditions.	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes [ ]	[ ]
	The assessment process has not identified any minor negative impacts.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you	Yes [x]	No [ ]
	How is it being monitored?	Monitoring of the risk assessment compliance and quality of completion, staff training, compliance with pathway 1-4 Discharge Procedures using Home First Principles management and incidence of Adult In patient falls will take place weekly and monthly as part of the suite of Ward Accreditation metrics which are captured via the IRIS

Part B Form 5: Summary of Key Findings and Actions

implement your policy or proposal?		electronic system which is well established within the In patients areas for the past 2 years. The metrics to monitor the policy such as Estimated Date of Discharge in greater detail will be additional metrics within this system.
	Who is responsible?	Ward Managers for data collection via Ward Accreditation metrics and progressive discharge profiles
	What information is being used?	Discharge Procedures using Home First Principles Data will be on display within In patient areas (wards) to support quality improvements, data will be shared at local Quality and Safety groups, Strategic Discharge Steering group and Patient Safety and Quality Group. Existing reports will be strengthened with the additional metrics. In addition, data will be used as part of the inpatient discharge profile learning panels.
	When will the EqIA be reviewed?	The EqIA will be reviewed at the same time as the policy requires a review.

7. Where will your policy or proposal be forwarded for approval?	Patient Safety and Quality group and Quality and Safety Executive Committee.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Naomi Holder	Director of Nursing
	Jayne Sankey	Interim Area Nurse Director
	Kristy Ross	Interim Head of Nursing
		Representation from Home First Team Senior Nursing Team
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No negative impacts identified		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	None ,		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	Not Applicable.		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	Not Applicable.		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

Report title:	MP03 Medical Device Training Policy		
Report to:	Quality, Safety and Experience Committee		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	2.3 QS22.119
Executive Summary:	This is a planned revision of the Medical Device Training Policy (MP03) for the Health Board		
Recommendations:	QSE is asked to: Approve the revised policy		
Executive Lead:	Executive Director of Therapies and Health Science		
Report Author:	Patrick Hill, Deputy Director Medical Physics [See Policy front page for Policy authors]		

Purpose of report:	For Noting ☐	For Decision ☒	For Assurance ☐
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

- Digital training records - Develop a proper system of digital training records for medical devices across the Health Board, capable of providing compliance figures and management reports for shortlist of high-risk devices. 24 months.
- In the meantime – consolidate sampling / audit of local records. 9 months

Link to Strategic Objective(s):	Linked through 'Planning Principles': • Excellent Care, • Right Place • Employer of Choice
Regulatory and legal implications	PUWER – Provision and Use of Work Equipment Regulations (1998) HASAW - Health And Safety At Work (1974)
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Main risk ID 1087 (Score = 20 extreme) – 'risk to patient safety if staff are not trained and competent in the use of high risk medical devices'. This risk was logged following a Coroner's Section 28 report around a user error with a defibrillator. This risk is partially mitigated by this Policy.
Financial implications as a result of implementing the recommendations	Not in approving the Policy itself. However work to address the risk above has the potential for future cost.
Workforce implications as a result of implementing the recommendations	Staff have responsibilities around training as in the Policy, both at individual and management

	levels. These responsibilities need to be recognised and owned.
Feedback, response, and follow up summary following consultation	- MDOG – added Audit arrangements (Sec.13) - HB Policies consultation web page – added reference to NU20 on Policy Title Page, and clarified arrangements for trainee staff. - CPPG – Typographical changes only. - PSQG – No changes requested.
Links to BAF risks: (or links to the Corporate Risk Register)	Links to: CRR21-16 Manual handling CRR21-19 Decontamination
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:
Implementation of recommendations.

The revised policy will be published, and staff will be briefed / reminded of the requirements.

List of Appendices:
1. Equality Impact Assessment (EqIA)

QSE MEETING DATE: 05-Jul-2022
REPORT TITLE: MP03 Medical Device Training Policy

1.   **Introduction/Background**

This is a planned revision of the Medical Device Training Policy (MP03) which is submitted to QSE for final approval.

Consultation has included:

- Medical Device Groups for East, Central, and West
- HB Medical Devices Oversight Group (MDOG)
- HB Policies consultation web page
- HB Clinical Policies & Procedures Group (CPPG) – 11-Mar-2022
- HB Patient Safety and Quality Group (PSQG) – 09-May-2022

2.   **Body of report**

The Medical Device Training Policy sets out the Health Board's training strategy to ensure that all relevant staff are suitably trained in how to use medical devices safely and effectively for the benefit of patients in their care. This Policy addresses an enormous range of medical devices used for diagnosis, treatment, prevention and monitoring in healthcare.

The Policy centres on a risk based approach to training as advocated by HSE, in which medical devices are classified according to the level of risk, and training needs are identified accordingly.

This planned revision updates the original Policy in a number of ways:-

Scope (Sec.5) – clarified the circumstances in which the Policy does, and does not apply.

Roles & Responsibilities (Sec. 6)
        Ward / Unit Managers – responsibilities expanded and clarified (Sec. 6.5)
        Introducing a New Medical Device – section added, including 70% requirement for training coverage (Sec 6.10)

Risk Based Training (Sec. 7)
        Major section added to explain the Red – Amber- Green risk grading of medical devices to inform the level of user training required.

Audit (Sec. 13)
        Section added to set out audit arrangements (added in response to consultation at MDOG)

Minor changes have also been made throughout the document to clarify wording, and update structures, names of groups, references etc.

[- Please see Policy document attached -]
[- 'Track changes' has not been used since the number of changes would have been difficult to follow -]
[- Welsh language – The Policy will be translated into Welsh when given final approval -]

3. Budgetary / Financial Implications

3.1 There are no new budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the HB Medical Devices Oversight Group.

4. Risk Management

4.1 The main risk on Datix linked to this area is risk ID 1087 (Score = 20 extreme). This risk was logged following a Coroner's Section 28 report around a user error with a defibrillator. This risk is partially mitigated by this Policy.

5. Equality and Diversity Implications

5.1 If this report relates to a 'strategic decision', i.e. the outcome will affect how the Health Board fulfils its statutory purpose over a significant period of time and is not considered to be a 'day to day' decision, then you must include both a completed Equality Impact (EqIA) and a socio-economic (SED) impact assessment as an appendix.

5.2 Following the EqIA / SEIA Quick Guide a completed EqIA is attached as appendix 1. (An SEIA is not required).

Medical Devices Training Policy

Author & Title	Buddug Jones-Bennett (Medical Device Trainer) Tracie Walkden-Williams (Medical Devices Nurse Lead) Lynsey Bellamy (Medical Device Safety Officer) Patrick Hill (Deputy Director Medical Physics)
Responsible Dept / director:	Exec Director of Therapies and Health Science
Approved by:	[BCUHB Medical Devices Oversight Group (MDOG) 22-Nov-2021]
Date approved:	*To be completed*
Date activated (live):	*To be completed*
Documents to be read alongside this document:	MP02 - Medical Devices and Equipment Management Policy NU20 - Intravenous (IV) Medication Administration by Bank and Agency Workers
Date of next review:	01-Mar-2025
Date EqIA completed:	02-Mar-2022
First operational:	November 2015
Previously reviewed:					
Changes made yes/no:	Yes				

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

CONTENTS:

1. **INTRODUCTION / OVERVIEW**

Medical Devices are used extensively in the care and treatment of patients within Betsi Cadwaladr University Health Board (BCUHB). Medical Devices deliver enormous benefits to thousands of patients every day. However, they must be used correctly to deliver those benefits, and keep patients safe from harm. In some cases user error can cause serious patient harm, or even death.

The Health Board recognises how important it is that staff understand how to use medical devices correctly and safely. This Policy is about achieving and supporting that understanding – by education and training, information resources, and assessment.

Fundamentally this Policy sets out a 'risk based approach' to staff training: ie that training should be in proportion to the risk of harm from user error. This approach is aimed at maximising the benefit to patients, and optimising the support to staff.

The term 'Medical Device' has a very wide scope, and is defined as 'an …article…which.. is intended …to be used for human beings for …-
- (i) diagnosis, prevention, monitoring, treatment or alleviation of disease,
- (ii) diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap,
- (iii) investigation, replacement or modification of the anatomy or of a physiological process, or
- (iv) control of conception;

and does not achieve its principal … action by pharmacological, immunological or metabolic means.' (Medical Devices Regulations [2002]).

Standard 2.9 of the Health and Care Standards for Wales (2015) states that all health service settings should have an on-going program of medical device competency training. To comply with this standard BCUHB Medical Device and Equipment Management Policy (MP 02) 2020 states '*all staff are expected to undergo suitable medical device training and that managers ensure that staff are appropriately trained and competent with medical devices used'.*

2. POLICY STATEMENT

The Betsi Cadwaladr University Health Board (BCUHB) is committed to continually improving the quality and safety of its services which includes ensuring that all relevant staff are suitably trained in the correct use, storage and appropriate cleaning / decontamination of all medical devices safely and effectively for the benefit of patients in their care.

The NHS also has statutory obligations relating to 'Duty of Care', this includes, to provide competent employees, safe equipment and safe working practices.

Under the Health and Safety at Work Act (1974), BCUHB has a legal obligation to provide training to its employees in the use of work equipment in cases where lack of training may increase the risk of harm to employees or patients.

3. AIMS / PURPOSE

The purpose of this policy is to set out a clear risk based training and learning strategy so that staff understand how to use medical devices correctly and safely, for the benefit of patients. This includes how training and learning needs will be identified, delivered, recorded and monitored. The policy makes clear the responsible parties for each step of this process, as well as stating how non-compliance to this policy will be monitored.

4. OBJECTIVES

- Through effective staff training and learning, ensure the benefits to patients from the use of medical devices are maximised and any risks minimised.
- Ensure that the Health Board has standardised systems in place, to identify, deliver, manage and record medical device training safely and effectively in compliance with legal requirements and national standards.
- Ensure the organisation has a realistic position with regard to the resources required to provide the appropriate Risk Based Training established in this policy.
- Ensures all staff are aware of the medical device training and competence requirements and the risk based approach to identifying these training needs.
- To detail the process for managing non-compliance to this policy.

5. SCOPE

This policy applies to:
- All staff groups (including Medical Staff) throughout the Health Board who use, or plan to use medical devices in the course of their work for the Health Board.
- Groups and individuals supervised by the Health Board and acting on behalf of the Health Board who may not be employed directly by the Health Board, including students, bank workers, volunteers, agency and locum staff. These individuals are also required to undertake appropriate training on the medical devices they use on behalf of the Health Board in their areas of operation.
- All types of medical devices recognised by the MHRA (UK Medicines and Healthcare Products Regulatory Agency).

This policy does not apply directly to:
- Commissioned or contracted services (whether at primary, secondary, or tertiary level).
  - In these cases, the Health Board will ensure suitable and timely assurances are gained from these contractors / providers in relation to

staff training in the medical devices they need to use, in line with contractual arrangements.

6. ROLES AND RESPONSIBILITIES

6.1 Chief Executive Officer
The BCUHB Chief Executive has overall responsibility for the safe use of medical devices. Training is a key component to this, not only for safety but also in compliance with the relevant internal and external standards, policy and legislation. It is the responsibility of BCUHB to provide adequate resources to enable the necessary training for staff. Where the organisation has an indication of inability to provide the necessary training there will be a clear escalation process to the Board through the Health Board's governance structure.

6.2 Quality, Safety, and Experience Groups
Quality, Safety, and Experience Groups are the governance structures responsible for ensuring adequate compliance with this Policy, and that suitable management arrangements are in place, including monitoring and compliance statistics.

6.3 Medical Device Oversight Group (MDOG)
The BCUHB Medical Device Oversight Group (MDOG) is responsible for monitoring compliance with this Policy on a corporate basis. MDOG and the Locality Medical Device Groups are responsible for escalating issues of concern in relation to training through the committee structure, up to Board level if required.

6.4 Site Managers
Site Managers are responsible for annual audit arrangements, as set out in the Audit section below.

6.5 Ward / Unit Managers
Ward / Unit Managers are required to draw up and maintain a 'Device List' of medical devices in use in their area, and their associated risk grading. This list is to be based on the 'Core List' (Appendix 1), with the addition of medical devices not currently listed there, but in use in their areas. This 'Device List' must be kept up to date, and made readily available to staff in the area.

Ward / Unit Managers are responsible for ensuring that their staff are adequately trained in the medical equipment they need to use.
- For new staff - this will include assessing their training needs at induction for the 'Device List' of medical devices in use in their area.
- For existing staff - this will include an annual review meeting. During this review meeting, a training schedule MUST be drawn up to highlight all medical devices used within the role for each individual staff member. This schedule should include details of how the identified training will be delivered, in line with this policy. This review should normally form part of staff Performance Appraisal Development Review (PADR). APPENDIX 1 is a suite of documents to assist in this process, including the Training Needs Review Form. The Training Needs Review Form will be used as the basis of the annual review and this form must be kept for audit purposes.

Ward / Unit Managers are also responsible for ensuring that any bank or agency workers assigned to their area are adequately trained in the medical equipment they need to use, and know that they are not to work beyond their level of competence. Attention is drawn to NU20 - *Intravenous (IV) Medication Administration by Bank and Agency Workers,* and the checklists in its appendices in particular.

Ward / Unit Managers must ensure that staff receive the identified training in a timely manner from the appropriate source. This can be from an authorised Key Trainer from their Ward / Dept, or an authorised Trainer from the equipment supplier, or from HB specialist teams (eg Resus Team, Medical Device Team etc.).

Ward / Unit Managers must also:
- Ensure there is an accurate record of training completed, as well as completed Self-Assessment forms, which are checked annually.
- Ensure that any Key Trainers within their area have received suitable Key Trainer training, which is updated regularly
- Notify the Locality Medical Device Group of any issues with provision, access, content, or quality of medical device training.

Ward / Unit Managers will recognise that students and trainees require particularly careful support and supervision. Ward / unit managers are responsible for the following in relation to any work with medical devices by students or trainees:
- • fully clarifying the scope of practice which applies to each individual, and the limits which that person must observe.
- • ensuring that there is appropriate and timely assessment of training and competence.
- • ensuring that there is adequate supervision and support at every stage.

Ward / Unit Managers are also responsible for ensuring that new devices are introduced safely, and that training issues are properly addressed. New devices are a particular risk issue, and this includes both short-term loans, and permanent acquisitions, and applies to all medical devices which are new (unfamiliar) to the area.
Detailed requirements around training are set out in the section below - 'Introducing a new medical device'.

6.6 All Clinical Staff
All clinical staff, including Medical Staff are responsible for;
- Working with their manager to determine individual training needs according to role and the medical devices used within that role.
- Ensuring their training is adequate and up to date.
- Ensuring there is an accurate record of training completed which is reviewed annually.
- Complying with both internal policies and external legislation regarding safety at work for both themselves and patients in their care.
- Ensuring that they perform competently with medical devices, and that they don't work beyond their level of competence.
- Informing a senior member of staff promptly if they are unable to perform competently with a medical device.

- Informing a senior member of staff promptly if a new (unfamiliar) medical device has been introduced / encountered without appropriate training, or if there are concerns that safe process has not been followed.

STAFF MUST NOT OPERATE A MEDICAL DEVICE UNLESS THEY ARE COMPETENT TO DO SO.
STAFF MUST NOT OPERATE A HIGH RISK ('RED RISK') MEDICAL DEVICE UNLESS THE APPROPRIATE TRAINING HAS BEEN COMPLETED.
OPERATING HIGH RISK MEDICAL DEVICES WITHOUT TRAINING CAN RESULT IN SERIOUS HARM TO THE PATIENT, AND MAY RESULT IN DISCIPLINARY ACTION FOR STAFF.

6.7 Medical Device Team

The BCUHB Medical Device Team responsibilities include:
For selected priority devices:-
- Developing, delivering and evaluating relevant and up to date Medical Devices Training Material.
- Ensuring availability of sufficient training sessions throughout the organisation
- Maintaining a register of staff who complete Key Trainer training.
.
More generally:
- Ensuring the availability of manufacturers' instructions.
- Producing and reviewing relevant BCUHB Medical Device Training Policy and procedures.
- Ensuring medical device training issues are reviewed and reported to Locality Medical Device Groups.
- Identifying current training needs through ongoing engagement with relevant teams (e.g. Electro-Bio-Medical Engineering [EBME]; Risk Department) on device issues.
- Reviewing and analysing Datix incident reports for trends across BCUHB to identify issues and inform the training process.
- Signposting staff to internal and external training providers where required
- Maintaining BCUHB intranet medical device pages.

6.8 Other Training Providers
Other Training Providers, External Companies, Equipment Manufacturers are responsible for:
- Planning and providing training and appropriate documentation in their specialist capacity including elements of the self-assessment criteria, with ongoing evaluation.
- Documenting and recording training activity detailing competencies achieved, a copy of which is forwarded to the manager who requested the training.
- Ensuring suitable company or Key Trainer training has been completed and kept up to date.

6.9 Other BCUHB Teams

EBME and relevant Patient Safety Teams are responsible for highlighting potential training needs to the Medical Device Team by continuing to communicate on device issues e.g. 'no fault found' issues and device incidents

The Decontamination Advisor and Infection Prevention Team are responsible for providing support and advice on issues relating to infection prevention and control in relation to Medical Devices in use within the Health Board.

6.10 Introducing a New Medical Device

Introducing a new medical device is a particular risk. Ward / Unit Managers are responsible for ensuring that new devices are introduced safely, and that training issues are properly addressed. This includes both short-term loans, and permanent acquisitions, and applies to all medical devices which are new (unfamiliar) to the area. This responsibility includes:

- Adding the medical device to the local 'Device List', including confirming its risk grading (Red / Amber / Green).
- For all risk grades - Ensuring that all relevant staff have been alerted to the introduction of a new device, that they have been briefed on the risk grading and the training requirements, that suitable User Information is readily available to relevant staff, and that all staff have been notified of this.
- Additionally, for 'RED' risk devices - Ensuring that proper training has been provided, completed, and recorded, with at least 70% of staff trained before the device is released to the area. This 70% requirement is in line with other Health Boards nationally and has been agreed by BCU Medical Devices Oversight Group (MDOG).
- Additionally, for 'AMBER' risk devices – Ensuring that appropriate training / demonstration / familiarisation has been provided, and formal written Self Assessment Forms have been signed and archived for at least 70% of staff before the device is released to the area. (See above for the 70% requirement).

For requirements on other aspects of introducing a new device see also:
- MP02a 'Procedure for the Selection, Loan, and Procurement of Medical Devices').
- MP02b Procedure for Commissioning (bringing into use) of Medical Devices.

7. RISK BASED TRAINING

Training is a key element in Medical Device safety. Healthcare professionals have a professional responsibility to ensure their skills, knowledge and training are appropriate and up to date for their area of work.

Medical Devices encompass such a wide range of products, ranging from very high risk devices to very low risk devices. For safe and effective staff training, training needs have been classified according to the level of risk each device carries. A Core List of Devices and associated risk is included as part of Appendix 1. Ward /

Specialist Areas are required to develop this Core List further to include any additional medical devices not currently listed but in use in their areas.

Training for Medical Devices in this Health Board has been classified as follows;

7.1 HIGH RISK DEVICES – 'RED RISK'

Red Risk devices are those that have the potential to cause serious adverse consequences or death should they be misused or fail. Any high-risk device carries a 'STOP' element, meaning that the device MUST NOT be used unless the user has received formal training to do so.

Formal training has been defined as that from either the Medical Devices Team, other Specialist Training Teams within the Health Board (eg Resus Team, Manual Handling Team), the Manufacturer's designated trainer, or a Ward /Unit Key Trainer who has received the appropriate Key Trainer training.
Formal training and assessment is always needed before using a 'RED' risk device.

Low Usage – Being unfamiliar with the device because of infrequent use increases the risks of errors. Review for update training is required annually and should form part of the PADR process. Update training must be received at least every three (3) years.

Failure to reach the required level of competency with any high-risk device means that the user will need to arrange repeat formal training and reassessment, and MUST NOT operate the device until this has been completed.

7.2 MEDIUM RISK DEVICES – 'AMBER RISK'

Amber Risk devices are those that would have significant impact in patient care or cause temporary adverse health consequences should they be misused or fail. Any medium risk device carries a 'PREPARE TO PROCEED' element, meaning that the device must only be operated by a user who is deemed competent in the use of the device following a formal written self assessment. The user must take advice and instruction from a senior, knowledgeable colleague, and read the manufacturer's Instructions For Use. A signed Self-Assessment Form confirming the user's knowledge and understanding of the device (Appendix 1) must be completed. User manuals / manufacturer's instructions must be readily available in all Departments / Wards, or via the Health Board's internal Staff Intranet.

A separate 'Self-Assessment' form must be completed for each individual Medium Risk Device before use. Copies of these are to be kept on the Ward / Dept.

A new Self-Assessment must be completed if there is a significant change in the medical device in question (eg the device is upgraded, or a new model is introduced).

NB: Failure to reach the required level of competency with any medium risk device means that the user will need to access a higher level of training, for example training from a Medical Device Trainer. After completing this training, the self-assessment must be repeated, and if signed off the user may proceed with the device. Users must not operate the device until this has been completed.

7.3 LOW RISK DEVICES – 'GREEN RISK'

Green Risk devices are those devices that are unlikely to cause any serious consequences, meaning the user can continue in a safe and sensible manner, referring to the manufacturer's instructions as needed.

8. EQUALITY INCLUDING WELSH LANGUAGE

This document complies with the Health Board's Equality and Diversity statement, which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website. An EqIA has been completed and no negative impacts have been identified. Where barriers exist or additional support / reasonable adjustments are required in understanding or implementing this policy, support will be available by contacting the Medical Devices Team.

9. WELL–BEING OF FUTURE GENERATIONS

The Health Board's Well-being objectives are to improve physical, emotional and mental health and well-being for all; this includes improving the safety and quality in all areas, respecting people and their dignity, as well as listening to people and learning from their experiences. This Policy supports all these elements by ensuring that medical devices are used correctly to deliver their intended benefits and minimise any risk of harm.

10. ENVIRONMENTAL IMPACT

A small amount of consumable waste will be an end product of some Medical Devices Training. This is reduced as much as possible by re-using consumables in multiple training sessions, where there are no contamination issues, and no patients involved. All waste produced will be dealt with in accordance with the appropriate Health Board policy.
Some staff travel is inevitable in providing and attending training, but this will be reduced where possible by Trainers travelling to site rather than multiple trainees travelling to the Trainer, and also by combining with other mandatory training sessions.

11. RESOURCES

The Risk Based Training strategy focuses training effort and resources according to where they will give the most benefit. Training Teams will continue to provide formal training for priority Red Risk devices, but will need to monitor training workload and resources to achieve adequate coverage. However staff will need sufficient time to attend training. Line Managers will need to ensure sufficient time is provided for staff to undertake appropriate training and learning, and to complete Self-Assessments for the Medium (Amber) Risk devices they use.

12. TRAINING AND IMPLEMENTATION

Once authorised the Medical Devices Team will ensure this policy revision is widely publicised throughout the Health Board liaising with Departments and Ward leads.

13. AUDIT

Site Managers are responsible for ensuring that a meaningful compliance audit is completed annually. This is to monitor the compliance with medical device training requirements, and provide assurance of correct process and record keeping. The audit results are to be provided to the Health Board Medical Devices Oversight Group.

The Medical Devices Oversight Group is responsible for reviewing the audit results for any issues where improvement is required, and for escalating issues of concern through the Health Board committee structures.

14. REVIEW

A review of this Policy will take place within 3 years of its ratification date unless required earlier.

15. REFERENCES
Several areas of legislation apply to medical devices and their use.
- Health and Safety at Work Act (1974) – available on line via WWW.HSE.GOV.UK
- Medical Devices Regulations 2002 (as amended) (UK MDR 2002).
- Electricity at Work Regulations 1989.
- Lifting Operations and Lifting Equipment Regulations (LOLER) 1998.
- Provision and Use of Work Equipment Regulations (PUWER) 1998.

16. APPENDICES

Appendix 1: Suite of documents to be used to identify staff training needs;
- Medical Device Training Needs Review Form (Template).
- Core List - Medical Devices & Risk Classification.
- Self-Assessment Form.

Medical Device Training Needs Review Form

Use this form in conjunction with your unit's RAG Rated List of Medical Devices at your Induction meeting or Annual Review meeting with your manager to identify your Medical Devices Training needs.

Name:		Staff No:
Job Title:		Site / Ward / Dept:

RED risk devices require formal training	AMBER risk devices require appropriate training / learning, and completing a Self-Assessment Form.	GREEN risk devices – training not normally required – 'common sense' should keep everybody safe.

List all the Devices you will be expected to use in your role on this ward / unit	Training level	Date booked	Date Training Completed or Self-Assessment completed & Signature	Renewal Due
Defibrillator (manual)	🟥			
Infusion Pump BBraun Infusomat space (volumetric)	🟥			
BBraun Perfusor space (syringe)	🟥			
T34 Syringe driver	🟥			
Blood Pressure Monitor				
ECG				
Electric Profile Beds:				
Enteral Feed Pumps:				
Mattresses (Dynamic):				
Nebulisers:				
O2 Flow Meters:				
Patient Hoists:				
Patient Warming:				
Suction:				
Thermometer	🟩			

RED RISK DEVICE – The devices that have been identified as HIGH RISK RED RISK are those that have the potential to cause **serious adverse consequences or death** should they be misused or fail. Any High Risk device carries a 'STOP' element, meaning that the device **MUST** not be used unless you have received formal training to do so. Formal training can only be delivered by The Medical Devices Training post, The Manufacturer's designated trainer, your unit designated Key Trainer. Formal training is always needed before using a RED risk device

Low usage can increase the risk of errors. Review for update training is required annually and should form part of the PADR process. Update training must be received at least every three (3) years, in any case.

NB: Failure to reach the required level of competency with any high risk device means that the user will need to arrange repeat formal training and reassessment and MUST NOT operate the device until this has been completed.

AMBER RISK DEVICE – Are those that would have significant impact in patient care or cause temporary adverse health consequences should they be misused or fail.
Any AMBER RISK device carries a 'PREPARE TO PROCEED' element, meaning that the device must only be operated by a user who has undertaken appropriate training / learning, and completed a written Self Assessment form to be deemed competent in the use of the device. The user will take advice and instruction from a senior, knowledgeable colleague, and read the official instructions for use. A signed Self-Assessment Form confirming the user's knowledge and understanding of the device (Appendix 1) must be completed.
A completed Self Assessment of competency for each device must be repeated once every three years in order to maintain competency with the device.

NB: Failure to reach the required level of competency with any medium risk device means that the user will need to access a higher level of training, for example training from a Medical Device Trainer. After completing this training the Self Assessment should be repeated and if passed the user may proceed with the device. Users must NOT operate the device until this has been completed.

GREEN RISK DEVICE – The devices that have been identified as low risk are those that are unlikely to cause any serious consequences should they be operated incorrectly.
Any low risk device carries a 'GO' element, meaning that users can continue in a safe and sensible manner and refer to the user manuals / manufacturer's instructions as needed. Further training can be arranged if it is deemed necessary by the ward manager or the user.

'Core List' - Medical Devices and Risk Classification Document

Device	Area	C	L	Score	Risk
Anaesthetic machines; vaporisers; ventilator	Theatre	5	5	25	High
Defibrillator (Manual Mode)	General	5	5	25	High
Infusion Devices (PCA; Epidural; Intrathecal)	Critical Care/General	5	5	25	High
Invasive Life Support Ventilators	Critical Care	5	5	25	High
Ultrasound/CT Scanner/MRI Scanner/X-Ray	Diagnostics	5	5	25	High
Infusion Devices (Volumetric/Syringe Pump/Driver)	General	4	5	20	High
Non-Invasive Ventilators	Critical Care/General	5	4	20	High
Renal Replacement Therapy – Acute and chronic	Renal	4	5	20	High
Diagnostic Endoscope	Theatres	4	4	16	High
Patient Hoist	General	4	4	16	High
Electro Surgery/Diathermy, CUSA, RF Generators	Theatre	4	4	16	High
Laser; Surgery	Ophthalmology	4	4	16	High
Pacemaker	Critical Care	4	4	16	High
Patient Monitoring – Catheter Laboratory	Theatres	4	4	16	High
Patient Monitoring – Nitric Oxide; Vaporiser	General	4	4	16	High
POCT – Lab Equipment/Blood gas; Glucose Meters	General	4	4	16	High
Lasers, Cryo units	Theatre	4	4	16	High
Airways Therapy O2 Delivery /O2 Flow meters	General	4	4	16	High
Suction units /electronic vacuum	General	4	4	16	High
Enteral Feed Pumps	General	3	3	9	Medium
Foetal Monitor	Obs & Gynaecology	3	3	9	Medium
Insufflators / Blood Warmers	Theatres	3	3	9	Medium
Interferential Treatment Unit	Physiotherapy	3	3	9	Medium
IPC Pumps - Flowtron DVT Pump	General	3	3	9	Medium
Patient Monitoring – Central Monitoring	Critical Care	3	3	9	Medium
Patient Monitoring – ECG/Telemetry/Event Recorder	General	3	3	9	Medium
Patient Monitoring – Pressure / Cardiac Output	Critical Care	3	3	9	Medium
Resuscitaire /Baby Incubator	Critical Care	3	3	9	Medium
Ultrasound Treatment	Physiotherapy	2	4	8	Medium
Electronic Beds	General	2	3	6	Medium
Endoscopy Ancillaries, Light Sources	Theatre	2	3	6	Medium
Exercise bike / CPM / Treadmill / Ergo meter	Physiotherapy	2	3	6	Medium
Patient Monitoring – Respiration / Apnoea / CO2 / O2	General	2	3	6	Medium
Patient Monitoring – SpO2	General	2	3	6	Medium
Patient Monitoring - Spirometer	General	2	3	6	Medium
Patient Monitoring – Temperature	General	2	3	6	Medium
Surgical Irrigation System	Theatre	2	3	6	Medium
Tourniquet	Critical Care	2	3	6	Medium
Treatment Lamp/Infrared/Phototherapy/Pulsed RF	Physiotherapy	2	3	6	Medium
Airways Therapy / Humidifier / Nebuliser	General	2	2	4	Low
Communication Aid	SALT	2	2	4	Low
Examination Couch & Chairs	General	2	2	4	Low
Operating Microscope	Theatre	2	2	4	Low
Ophthalmoscope, Sight Tester, Visual Field	Ophthalmology	2	2	4	Low
Patient Monitoring - NIBP	General	2	2	4	Low
Weighing Scales; Standing, Sitting, Bed	General	2	2	4	Low
Wax Therapy, Hot / Cold	Physiotherapy	2	2	4	Low
Illumination Light Source, Video Systems, Displays	Theatre	1	3	3	Low
Patient Warming / Cooling – Warming Blanket	Critical Care	1	2	2	Low

Key: **C = Consequence   L = Likelihood** (Risk Management Matrix)

Medical Device: Self-Assessment Form

Please use the statements in the table below to self assess competence and confirm that you have the knowledge and skills needed for practice before considering yourself competent with a piece of equipment. If you are not competent, please access training or resources and reassess. These statements are designed to indicate competence to use a medical device. Responsibility for use of any medical device remains with the user so if you are uncertain regarding your own competence to use a device you should access appropriate training and not use the device until this has been done and you do feel competent in using the device as described in the BCU Medical Device Policy (MP02). Training can range from formal classroom 'workshops' to accessing the manufacturer's manuals and guides.

	Questions to ask yourself for self assessment:	Knowledge and skills:
1	Do you know the clinical application and indications for use of the product?	YES / NO / NA
2	Do you understand the contra-indications / Risks?	YES / NO / NA
3	Do you know how to set up the medical device for use on a patient?	YES / NO / NA
4	Are you capable in the use of the device on a patient?	YES / NO / NA
5	Can you recognise potential signs of operational malfunctions of the device and understand steps to be taken to identify the cause?	YES / NO / NA
6	Are you able to recognise battery level, status and life span for this device?	YES / NO / NA
7	Do you know where the alarms / controls are positioned, what they're used for and what actions should be taken to resolve any alarms?	YES / NO / NA
8	Do you know how and where the device should be stored?	YES / NO / NA
9	Are you using the device as per manufacturer guidelines/intended purpose?	YES / NO / NA
10	Do you know what consumables are needed to operate the device and where they are kept and how long they can be used for?	YES / NO / NA
11	Is this a re-usable medical device?	YES / NO / NA
12	Do you know the method of cleaning recommended by the manufacturer?	YES / NO/ NA
13	If more than a simple clean is needed, have you been trained in right processes?	YES / NO/ NA
14	Are you aware of the Risk Category associated with the device?	YES / NO / NA
15	Are you aware of where manufacturer user instructions are & how to access?	YES / NO/ NA
16	Will you be using any additional specialist functions on this device?	YES / NO/ NA
17	If 'YES' do you fully understand the functions / indications for this?	YES / NO/ NA

Name:	Staff No.:
Job Title & Ward :	Device Details :
Device Type / Model:	
I confirm that I have assessed my knowledge of this device against the above self-assessment criteria & if needed have read and understood the Manufacturer's Directions for Use I feel fully competent in its operation	
Signature:	**Date:**

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

GIG CYMRU NHS WALES

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

<u>For:</u>	Medical Devices Training Policy – MP03 (revised)
<u>Date form completed:</u>	13-Jan-2022
	Finalised 02-Mar-2022

PARTS A: SCREENING and B:
KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A   Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Medical Devices Training Policy – MP03 This EqIA relates to the revision of the existing policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The aim is that all relevant staff understand how to use medical devices correctly and safely, for the benefit and safety of patients. This will be addressed by having a clear risk based training and learning strategy. Objectives: • A standardised system in place to identify, deliver, manage and record staff training and learning in medical devices, to underpin good patient care and patient safety. • To meet legal and professional requirements on the Health Board in relation to training its staff in the medical equipment they use. • That all relevant staff are aware of the medical device training and competence requirements, and the risk based approach to identifying and meeting these training needs.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Exec Director of Therapies and Health Science
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Under the Health and Safety at Work Act (1974), BCUHB has a legal obligation to provide training to its employees in the use of work equipment in cases where lack of training may increase the risk of harm to employees or patients.

Part A   Form 1: Preparation

Please answer all questions

5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Key Stakeholders • Almost all clinical staff in relation to undertaking training and learning • Senior managers in relation to managing, monitoring, and assurance
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Help: - Good communication for staff awareness - Good record systems (digital) - Adequate staffing levels so that staff can be released for training Hinder: - Changing management structures - Competing priorities for staff time
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	This Policy is about ensuring that training and support is available all staff in the medical devices they need to use. This includes the requirement for regular reviews for all staff of their training needs. This applies to all staff. This will help ensure that that patients receive best care in circumstances where medical devices are used.

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

Please answer all questions

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

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

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

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

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

Part A

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

Please answer all questions

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

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

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. For the definitions of each characteristic please click here					
	Yes	**No**	**(+ve)**	**(-ve)**		
Age		X			This Policy relates mainly to Health Board staff ie people of working age. It also relates to much smaller numbers of people supervised by the Health Board and acting on behalf of the Health Board who may not be employed directly by the Health Board – some of this group will be older people (eg some volunteers), and some may be younger people (eg students, trainees). This Policy positively requires all these individuals to be supported by regular review of their training needs for the medical devices they use. It also requires line managers to ensure these training needs are met. Training methods may need to be mindful of checking levels of digital confidence for people. Generation Y (born after 1979) are recognised to be more at ease with using technology. Supporting information about our workforce and age:	Training methods may need to be mindful of checking levels of digital confidence for people.

Part A

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

Please answer all questions

					Context of BCU workforce and age: • 39% of staff are aged 50+ • 5% of the workforce is under 25 years of age. • 15% is 30 years of age or younger. • The over 50s are forecast to be to be the fastest growing group within the workforce Source: Adapted from BCUHB statutory employment records for 2020/21	
Disability		X				This Policy relates to people working for the Health Board, or on behalf of the Health Board, who use medical devices. It is about meeting the individual's training needs in relation to medical devices so that they can fulfil their current duties. Considerations will be given to disabled staff who may require reasonable adjustments within training situations. Task based risk assessments will need to be developed for individual circumstances. These considerations are out of scope for this policy but are part of wider BCU policies and procedures. Additional disability data collated for statutory employment records for 2020/21 indicates:	Considerations will be given to disabled staff who may require reasonable adjustments.

Part A

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

						Number	Percent	
					Disabled	856	4.52%	
					Not Disabled	14773	78.08%	
					Not Disclosed	2463	13.02%	
					Unknown	829	4.38%	
					Total	**18921**	**100.00%**	
Gender Reassignment (*Sometimes referred to as 'Gender Identity' or transgender.*)		X			This Policy does not relate to gender or gender re-assignment. It does not relate to the provision or use of physical facilities such as changing rooms or toilets. The Policy does not use he / him / his or she / her pronouns. Individuals undergoing Gender reassignment are advised during treatment/post surgery against lifting heavy items. There is a potential impact on an individual that may be required to carry equipment as part of their role. Each case will need to be considered on an individual basis with task based risk assessments and safe ways of working developed. These arrangements sit within wider BCU policies and procedures.			Make reasonable adjustments for individual circumstances where advised against lifting. These arrangements sit within wider BCU policies and procedures.

Part A

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

Pregnancy and maternity		X			Pregnant staff who will continue to be trained in medical devices for the duties they are undertaking at the time. Staff would not normally receive training during maternity / paternity / adoption leave, unless by agreement during Keeping In Touch days. Organisers of training sessions are expected to make suitable arrangements for any staff that are breastfeeding if required, but this level of detail is beyond the scope of this Policy. There is an impact on pregnant individuals that may be required to carry equipment as part of their role. Pregnant staff are required to undertake risk assessments to ensure safer working during pregnancy. These arrangements sit within wider BCU policies and procedures. This Policy relates to all individuals irrespective of their family status.	Make reasonable adjustments for individual circumstances where advised against lifting. These arrangements sit within wider BCU policies and procedures.
Race		X			This Policy is about training staff and service providers in the medical equipment they use. Access to training is not affected by race or ethnicity issues. All individuals who satisfy the Health Board requirements for language and communication will have equivalent access to training.	

Part A

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

Table showing number staff ethnicity:

	Number	Percent
White	17022	89.96%
Black or Black British	144	0.76%
Asian or Asian British	583	3.08%
Mixed	114	0.60%
Chinese	29	0.15%
Any Other Ethnic Group	188	0.99%
Unknown	841	4.44%
Total	**18921**	**100.00%**

Source: Statutory Employment Report 2020/2021

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

Religion, belief and non-belief		X			This Policy is about training staff and service providers in the medical equipment they use. Access to medical device training is the same as other types of training – it is equivalently available to all individuals whatever their religion / belief status. The Policy does not relate to or adversely affect religious rituals, dietary requirements, or dress code / uniform requirements. Data showing staff reporting for Religion and Belief from BCUHB Statutory Staff Employment Report 2020-21:	

	Number	Percent
Atheism	2308	12.20%
Buddhism	70	0.37%
Christianity	9555	50.50%
Hinduism	169	0.89%
Islam	173	0.91%
Jainism	*	*
Judaism	9	0.05%
Sikhism	13	0.07%

Please answer all questions

					Other	2085	11.02%
					Not Disclosed	3706	19.59%
					Unknown	830	4.39%
					Total	**18921**	**100.00%**
Sex		X			This Training Policy applies equivalently to all individuals of any sex. Men and women should not be adversely affected or disadvantaged in relation to this policy. Our workforce is over 80% female of which a large proportion work part time. Tables showing female / male representation across BCUHB. Adapted from the BCUHB full statutory employment report 2020/2021.	Delivery of training may need to require flexibility of delivery to meet the needs of workforce. This will fall within individual team arrangements.

Part A

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

	Number	Percent
Female	15258.00	80.64%
Male	3663.00	19.36%
Total	**18921.00**	**100.00%**

| Sexual orientation | | X | | | This Training Policy applies equivalently to all individuals of any sexual orientation. No group is adversely affected or disadvantaged in relation to any other. Data for sexual orientation from BCUHB Statutory Employment Report 2020/21 shows: | |

	Number	Percent
Heterosexual	15106	79.84%
Gay	119	0.63%
Lesbian	113	0.60%
Bisexual	98	0.52%

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

Please answer all questions

					Not Disclosed	2659	14.05%
					Unknown	826	4.37%
					Total	**18921**	**100.00%**

Marriage and civil Partnership (Marital status)		X			This Training Policy applies equivalently to all individuals of any marital status. No group is adversely affected or disadvantaged in relation to any other.	

There are no next of kin issues impacted by this Policy.

Data on marital status from BCUHB Statutory Employment report 2021/22 shows:

	Number	Percent
Civil Partnership	321	1.70%
Divorced	1474	7.79%
Legally Separated	141	0.75%
Married	10045	53.09%
Single	5367	28.37%
Widowed	231	1.22%
Unknown	1342	7.09%
Total	**18921**	**100.00%**

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

Please answer all questions

Socio Economic Disadvantage		X			This Training Policy for using medical devices applies equivalently to all staff and service providers. No relevant socio-economic group is adversely affected or disadvantaged in relation to any other. There should be no cost implication for staff in relation to this policy.	.

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

Please answer all questions

Human Rights:

Do you think that this policy will have a positive or negative impact on people's human rights?

This Policy will have a positive impact on human rights in that it directly supports and enables the use of medical devices in treatment and diagnostics to preserve life, and limit suffering.

For more information on Human Rights, see our intranet pages at: http://howis.wales.nhs.uk/sitesplus/861/page/42166 and for additional information the Equality and Human Rights Commission (EHRC) Human Rights Treaty Tracker https://humanrightstracker.com.

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	**No**	**(+ve)**	**(-ve)**			
X		X		*Article 2:* Right to life	Modern healthcare relies extensively on the use of medical devices. Training staff and service providers to use medical devices correctly is fundamental to patients receiving effective treatment to protect life, and limit suffering. Mistakes with medical devices can cause serious harm, or even death, and user training reduces this risk as well. This can also cause distress for staff and impact on their ability to do their job.	Not applicable – impact is positive

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

Please answer all questions
Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		X			This Policy is about medical device training. It does not explicitly set out opportunities to use the Welsh language in training staff and service providers.	
Treating the Welsh language no less favourably than the English language		X			This Policy is consistent with current Health Board language practice in providing technical / clinical training to staff and service providers.	

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	*Engagement work on this policy has involved clinicians.* • *Medical Device Oversight Group* • *Locality Medical Device Groups (multi-disciplinary)* • *NWMCS PSQE forum*
Have any themes emerged? Describe them here.	*No emerging themes identified.*
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	*None identified.*

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this* *section please click here training vid p13-18)*	Medical Devices Training Policy – MP03 This EqIA relates to the revision of the existing policy

2. Brief Aims and Objectives: (Copy from Form 1)	The aim is that all relevant staff understand how to use medical devices correctly and safely, for the benefit and safety of patients. This will be addressed by having a clear risk based training and learning strategy. Objectives: • A standardised system in place to identify, deliver, manage and record staff training and learning in medical devices, to underpin good patient care and patient safety. • To meet legal and professional requirements on the Health Board in relation to training its staff in the medical equipment they use. • That all relevant staff are aware of the medical device training and competence requirements, and the risk based approach to identifying and meeting these training needs.

From your assessment findings (Forms 2 and 3):

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes		No	✓
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes		No	✓
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider	Yes	✓	No	

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ▢ No ✓		
	No requirement for full impact assessment has been identified.		
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes ▢ No ✓		
	The assessment identifies some areas of consideration that are part of BCUHB policies and procedures. These relate to staff who share the protected characteristics of age, pregnancy, disability and gender reassignment.		
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes ✓	No ▢	
	How is it being monitored?	Training and audit work will be in place to ensure that any staff using medical devices have the competency to use them.

Via PADR (personal development)

Datix procedures are also in place across the Health Board. | |
| | Who is responsible? | Exec Director of Therapies and Health Science | |

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	To ensure compliance to the policy and ensure safe use of medical devices.
	When will the EqIA be reviewed?	This will be reviewed when this policy is reviewed.

7. Where will your policy or proposal be forwarded for approval?	*Usually a committee / group. **Please note it is not the role of the Equality team to approve your EqIA.***

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity**	Name	Title/Role
	Patrick Hill	Dirprwy Pennaeth Ffiseg Meddygol / Deputy Director Medical Physics
	Jen Dowell-Mulloy	Equality Manager (for review work)

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

Senior sign off prior to committee approval:	Patrick Hill	Dirprwy Pennaeth Ffiseg Meddygol / Deputy Director Medical Physics
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No further actions currently required.		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?			

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	No negative impacts currently identified.		
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	No negative impacts currently identified.		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	Further considerations given for staff who share protected characteristics.		

Report title:	Mental Health Improvement update		
Report to:	QSE		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	3.1 QS22.120
Executive Summary:	This is an update report following the presentation of the mHLD improvement plan to QSE in May 2022		
Recommendations:	The Board is asked to: Note this update and the continued work to develop the MHLD improvement work, more closely aligning to the transformational approaches of the Board		
Executive Lead:	Teresa Owen		
Report Author:	Iain Wilkie		

Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☒

Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Link to Strategic Objective(s):	Delivery of safe and effective care
Regulatory and legal implications	
In accordance with WP7 has an EqIA been identified as necessary and undertaken?	N This paper is an update of a prior paper WP7 Procedure for Equality Impact Assessments
In accordance with WP68 has an SEIA identified as necessary been undertaken?	N This paper is an update of a prior paper WP68 Procedure for Socio-economic Impact Assessment.
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	
Financial implications as a result of implementing the recommendations	None

Workforce implications as a result of implementing the recommendations	None directly
Feedback, response, and follow up summary following consultation	This is a presentation of the divisions further work, together with the boards transformation and improvement team to describe the work in process to deliver the divisions improvement approach
Links to BAF risks: (or links to the Corporate Risk Register)	
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:

Implementation of recommendations

The division will continue to report on its implementation of the improvement approach via its updates to the board

List of Appendices:

    The MHLD Improvement Plan

BOARD OF DIRECTORS MEETING IN PUBLIC
5/7/22

Mental Health Divisional improvement plan update

1. Introduction/Background

1.1 This presentation is a further update to the board of the divisional improvement approach and work done together with the transformation team to deliver the improvement.

2. Body of report

2.1 Please see the presentation to follow.

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the executive director for Mental Health.

4. Risk Management

4.1 None directly

5. Equality and Diversity Implications

5.1 This is an update report and does not,   in itself relate to a strategic decision.

MHLD Improvement Plan

16 June 2022

Historical and current context

Background

There has been a number of individual reports and significant incidents both past and present in the division with external scrutiny. Of note, the Hergest Unit has been a subject of a number of these.

Following each, the Division has developed actions plans in response.

There has been continuous improvement responding to these individual issues but it was felt that an approach that would bring together this information would increase our opportunity to apply the learning across the whole division and transform our services.

We concluded that a wider triangulation of information was required to inform a **MH&LD wide improvement plan.**

Triangulation

A triangulation exercise was undertaken, supported by Workforce and Organisational Development, with **thematic analysis of multiple discoveries of concerns and issues.**

Multiple sources of information have been used in order to triangulate findings.

Sources of information have included (but not limited to):

HIW reports	Concerns, complaints, patient stories	Holden Report
Public Services Ombudsman reports	Legal and Risk reports	Data available from the BCU Performance Team, and WG
SUI investigations	Coroner reports, including Regulation 28	Ockenden
Workforce data	Behaviour and Performance management	HASCAS

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

Triangulation

Triangulation confirmed that
- there were cross cutting themes that were being responded to at micro, meso and macro system level
- improvements were required, but supported by a longer-term approach that would better secure embedded changes in practice
- an approach steeped and disciplined in improvement science was needed

It also informed a plan built around 6 main stream **themes:**
- Back to basics
- Leadership, empowerment, culture & OD
- Safe & Effective care
- Individualised & timely Care
- Environment & resource
- Audit, Outcomes & Assurance

Current position

Immediate action plans continue to be actively addressed

Alongside, a substantive **MH&LD Improvement Plan** is being implemented which will

- incorporate the progress made in the immediate action plans for HIW reports , to take a Divisional wide and longer-term approach,

- be structured around the 6 key themes referred to in the previous slide

- be built upon improvement best-practice

- have a focus upon high-assurance, corroborated, evidence of embedded improvement

Future plans and actions

Improvement Methodology

Firm approach to evidence-based methodology, bringing in
- Institute of Healthcare Improvement (IHI),
- Managing Successful Programmes (MSP), and
- Kaizen/Lean theory

Dedicated Improvement support
Dedicated Divisional Improvement Plan lead

Commitment from BCUHB Improvement Team to provide support alongside externally recruited interim dedicated support

Grip and Control

We recognise there is a need to increase 'grip and control' to support delivery and subsequent assurance.

Significant element of stream 1 (Back to basics) is about ensuring the Divisional infrastructure and processes are in place to allow appropriate grip, control and remedial intervention.

Includes:

- Senior Leadership Team (SLT) diagnostic and support plan
- Refresh of SLT PADRs and objectives to reflect the Improvement Plan
- Incorporation of relevant parts of Improvement Plan in all PADRs throughout the division
- SRO monitoring meetings (initially weekly) in place as part of programme architecture.
- Regular Divisional Executive & Independent M presence

Taxonomy
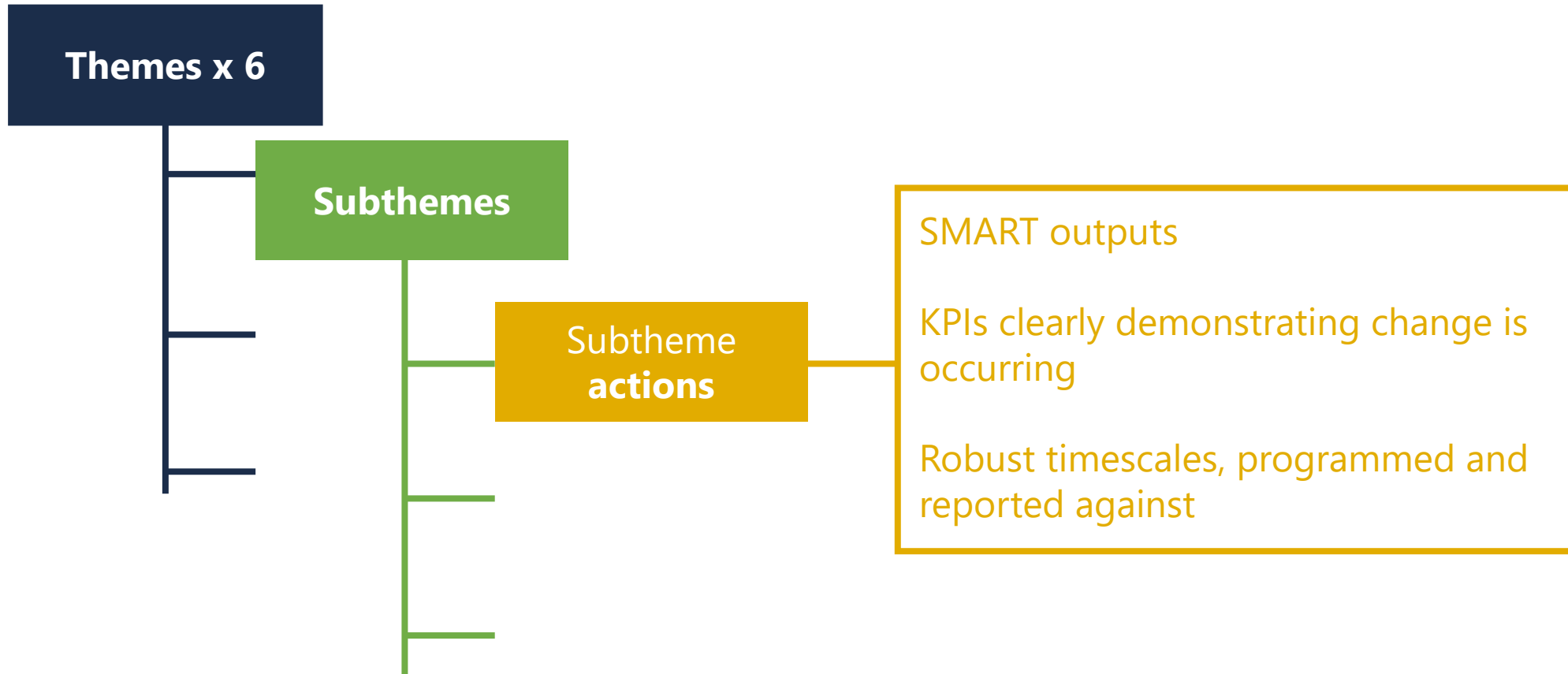
Themes x 6

Subthemes

Subtheme **actions**

SMART outputs

KPIs clearly demonstrating change is occurring

Robust timescales, programmed and reported against

Reporting lines
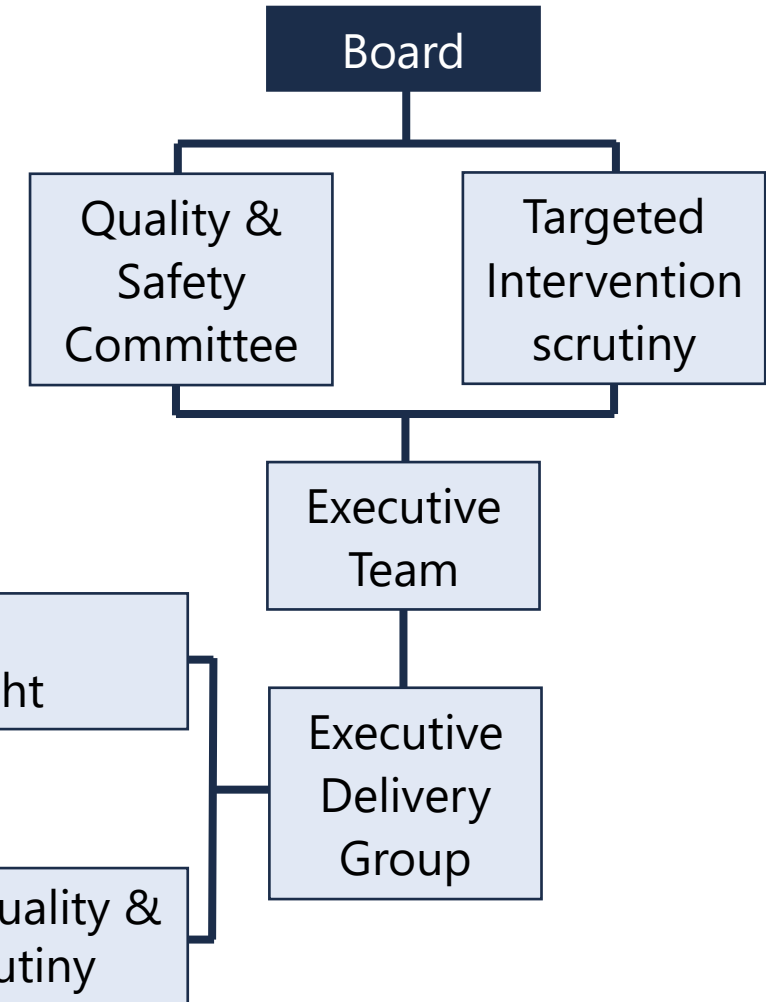
Outline Plan Architecture

6 Streams of work

Subthemes for Stream 1

Subthemes for Stream 2

Subthemes for Stream 3

Subthemes for Stream 4

Subthemes for Stream 5

Subthemes for Stream 6

Subtheme actions

1.1	Leadership development at team & divisional level	
1.1.1	Senior Leadership roles to be appointed	What does the current senior leadership team structure look like? Does it need reviewing prior to substantive recruitment? What type of person are we looking for - values & behaviours?
1.1.2	Leadership & management developmental strategy	TNA? Engaging with a BCUHB wide clinical leadership and management scheme; Proactive strategy to enable current and future leaders to identify themselves and then be supported in their development through training, coaching etc.
1.1.3	PADR	Developing clear career pathways for clinicians specialising in psychological therapies - but this should include all clinicians?

A note on the sub-theme actions

Tasks are close to being agreed, grouped into the sub-themes and then themes. The amount of tasks will change as stream leads are identified and work begins on developing SMART outputs, monitoring KPIs, and timescales.

Please note that concurrent with this work is the progression of immediate assurance plans in response to HIW and also HSE.

High level Gantt

TIER 4: PHASED IMPLEMENTATION OF IMPROVEMENTS – HI LEVEL GANTT

Following prioritisation exercise, the improvement plan will commence with those 'must do' improvements

Key:
- In progress
- Complete
- Not yet started

Detailed stream Gantt's to be populated (as per previous slides)

Governance and Assurance

Governance and Assurance

- Aligned to the three lines of defence model.

- Brings together and aligns key governance processes e.g. a more robust performance and accountability framework.

- Allows for primary routes of escalation, with secondary routes for backup

- Introduces duty to escalate and cascade.

- Introduces local responsibility/leadership for governance linked to corporate function.

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

Governance and Assurance

- Enhanced and co-ordinated delivery structures throughout the Health Board providing evidence based assurance.

- Consistent and co-ordinated delivery of Health Board strategic objectives, supporting strategies, and Board priorities throughout the structure.

- Defined structures throughout the Health Board (any variances to be centrally agreed).

- Flexibility to allow for local prioritisation (local prioritisation would trigger the duty to escalate).

- Floor to Board via multiple routes (e.g. Line management, Delivery Groups, Performance meetings etc.), for Board Assurance, incorporating deep dives, and board to floor quality dashboards.

- The refresh and strengthening of the floor to board dashboard including the data sources

- Working with external bodies to validate assurance, in line with 3 lines of defence model

Governance and Assurance

- Utilises the 3 lines of defence model – assurance not reliant on line management alone.

- Enhanced, centrally co-ordinated compliance monitoring mechanism triangulating quality and safety of all regulators that regulate Health Board activity.

- Integrated assurance approach to enable a more proactive risk mitigation process.

- Proactively review, triangulate and escalate through line management and delivery structure.

- Quality assurance (evidence based) of implementation of local action plans and ensure learning is shared across the Health Board.

- Three line of defence check and challenge within each level and between levels of the Health Board

- Alignment to the Targeted Intervention framework

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

Reporting lines

Report title:	Draft Risk Management Strategy		
Report to:	Quality, Safety and Experience Committee		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	3.2 QS22.212
Executive Summary:	The 2022/2025 strategy is submitted to the Quality, Safety and Experience Committee for consultation ahead of its consideration by the Board in July This follows a series of consultation events including a review of the strategy and Board Assurance Framework highlights at the Board Workshop on the 17th of June 2022		
Recommendations:	The Quality , Safety and Experience Committee is asked to: • Note and endorse the objectives of the risk management strategy • Note and endorse the Risk Management Strategy for Board Approval in July 2022		
Executive Lead:	Board Secretary		
Report Author:	Molly Marcu, Interim Board Secretary		

Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒

Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

Not applicable

Link to Strategic Objective(s):	ALL
Regulatory and legal implications	Alignment to regulatory requirements associated with delivery of patient care as well as a safe working environment under the Health and Safety at Work Act
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty **is applicable and provide an explanation below**	Y
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	(summarise risks here and provide further detail) (crynodeb o'r risgiau a rhagor o fanylion yma)

Financial implications as a result of implementing the recommendations	Risk Management training will be required as part of the process of enhancing the risk maturity of the organisation
Workforce implications as a result of implementing the recommendations	Not applicable
Feedback, response, and follow up summary following consultation	Feedback received from Executive team, QSE Chair, PFIG Chair
Links to BAF risks: (or links to the Corporate Risk Register)	All
Reason for submission of report to confidential board (where relevant)	Not applicable Amherthnasol

Next Steps:

- Following consultation with the Committee the strategy will be submitted to the Board in July

- The Risk Management policy will also be reviewed to ensure it is aligned to the strategy and submitted to a further QSE Committee for approval

List of Appendices:

- Risk Management Strategy, Appendix 1
- Equality Impact Assessment, Appendix 2

Risk Management Strategy

2022 - 2025

Document Reference No.	V.8
Target audience	Health Board Wide
Author	TBC
Group responsible for developing document	Health Board
Status	Draft
Authorised/Ratified By	Health Board
Authorised/Ratified On	TBC
Review Date	TBC
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	TBC

Contents

1. INTRODUCTION

1.1. The Betsi Cadwaladar Health Board is committed to providing high quality patient services in an environment where patient and safety is paramount. However healthcare provision has an inherent level of risk that cannot always be eliminated.

1.2. The Health Board Risk Management Strategy provides a framework for the robust identification, assessment and management of risks to the delivery of strategy and of high quality healthcare by enabling staff to:

    1.2.1.   Identify actual or potential risks

    1.2.2.   determine how best to treat them

    1.2.3.   apply the treatment

    1.2.4.   monitor the effectiveness of that treatment while supporting the safe development of clinical care and maintaining continuity of service delivery.

1.3. Every member of staff is responsible for effective risk management.

1.4. The Health Board promotes a just, compassionate responsible culture that fosters learning, improvement, and accountability. It intends all staff to be able to raise issues of concern and be listened to.

1.5. The Health Board recognises that complete risk control/avoidance is impossible, but risks can be minimised by making sound judgements from a range of fully identified options.

1.6. The Health Board is fully committed to ensuring a robust process is in place to ensure risks are identified, evaluated and mitigated to an acceptable level in a timely manner wherever possible.

2. PURPOSE

2.1. The Risk Management Strategy is a framework for the continued development of the risk management process, building on principles and plans linked to the Board Assurance Framework, the Risk Register and meeting requirements of Regulators such as Health Inspectorate Wales, Health and Safety Executive, along with national priorities.

2.2. The Risk Management Strategy aims to deliver a pragmatic, effective multidisciplinary approach to Risk Management, underpinned by the "Ward to Board" accountability and devolved governance structure.

3. STRATEGIC OBJECTIVES

3.1. This strategy supports the delivery of the Health Board's Living Healthy, Staying Well, strategic aims, agreed by the Board in July 2022, which are outlined below:

    3.1.1. Improve physical, emotional and mental health and well-being for all

    3.1.2. Target our resources to people who have the greatest needs and reduce inequalities Support children to have the best start in life

    3.1.3. Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being

    3.1.4. Improve the safety and quality of all services

    3.1.5. Respect people and their dignity

    3.1.6. Listen to people and learn from their experiences

3.2. The Health Board Strategic aims will be delivered through the following enabling strategies:

    3.2.1. Clinical Service Strategy

    3.2.2. People Strategy

    3.2.3. Estates Strategy

    3.2.4. Digital Strategy

    3.2.5. Quality Improvement Strategy

    3.2.6. Risk Management Strategy

3.3. As part of the delivery of these strategies appropriate mitigations will be put in place to ensure significant risks are proactively identified and mitigated as part of their delivery.

3.4. The delivery of this Risk Management Strategy will enable the embedding of an infrastructure that enables robust identification and management of risks that may prevent the achievement of Health Board objectives.

3.5. The Board will approve and monitor the delivery of these strategies and mitigations of associated risks through its Committees.

3.6. ***The work plan of each Board committee will incorporate agenda items which will ensure risks to the delivery of our strategies are identified and managed as appropriate.***

3.7. Section 8 provides more detail on Board Committees and their specific responsibilities.

4. OBJECTIVES OF THE RISK MANAGEMENT STRATEGY

4.1. The objectives of the Risk management strategy are:

*4.1.1. To **proactively identify**, manage and monitor significant risks that the Health Board is exposed to during the delivery of patient care, as well as its wider objectives*

4.1.2. To ensure that risks that can materially impact on the Health Board's key statutory objectives are proactively identified, assessed and managed

4.1.3. To enhance the risk maturity of the Health Board from Risk Aware to Risk Enabled

4.2. The Strategic Objectives of the Health Board evidence the Board prioritising patient safety, quality of care, staff wellbeing and development, and achievement of national standards.

4.3. The Health Board Performance and Risk Management Frameworks will be integrated, to ensure risks related to performance indicators are identified, treated and monitored to minimise the impact on quality. ***Performance indicators will be integrated with the Board Assurance Framework.***

4.4. At an operational level, the Health Board will apply ***a proactive risk management approach to identify risk through analysis of performance data and an Early Warning Trigger Tool***, described in detail in section 13.

4.5. A quality impact assessment tool will be used to identify possible risks to quality and safety arising from service re-design savings initiatives or variations in service delivery, such as bed pressures.

4.6. Themes from a number of quality and safety indicators including patient safety incidents, mortality reviews, complaints, and claims will be used to identify risks to quality, and trends used to assess whether previously identified risks are managed appropriately.

4.7. The Health Board will also use learning from experience as a risk mitigation approach.

4.8. This is covered in more detail in section 12.5.

Objective 3: *To increase the risk maturity of the Health Board from Risk Aware to Risk Enabled*

Figure 2: Risk Maturity scale
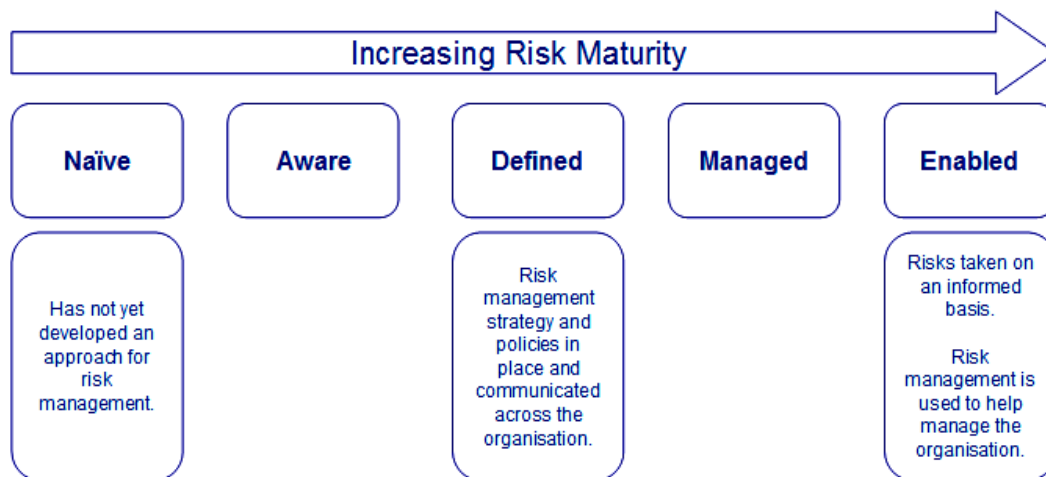
4.9. Figure 2 above shows the different levels of risk maturity that the Health Board can achieve as risk managements becomes embedded in the organisation.

4.10. The Health Board intends to enhance the risk maturity of the organisation to 'Risk Defined by March 2024, and achieve 'Risk Enabled' status by 2025.

4.11. The Board will review its risk maturity, appetite and Board Assurance Framework annually at the end of each financial year.

4.12. The Annual internal audit of risk management will include an assessment of the risk maturity of the organisation. The Audit Committee will monitor the implementation of any recommendations arising from this audit.

5. RISK APPETITE

5.1. Risk appetite is the total level of risk exposure, or potential adverse impact, that the Health Board is willing to accept in pursuit of its objectives.

5.2. The pursuit of one objective may hinder the achievement of another and this will impact upon the associated risk appetite. Similarly, the relative importance of one objective against another may be influenced by external factors, such as changes in national policy.

5.3. The Board recognises the importance of a robust and consistent approach to determining risk appetite to ensure:

   5.3.1. The organisation's collective appetite for risk and the reasons for it are widely known to avoid erratic risk taking, or an overly cautious approach which may stifle growth and innovation.

   5.3.2. Health Board Managers and senior leaders know the levels of risk that are legitimate for them to take, and opportunities appropriate to pursue, to ensure service improvements and patient outcomes are not adversely affected.

5.4. To value and compare the relative merits and weaknesses of different risks, the Health Board will determine the level of risk the organisation is willing to tolerate in different areas.

5.5. This will include deciding whether the Health Board will *treat, tolerate, transfer or terminate a risk and what the organisation's 'target risk score' should be. Operating within risk tolerances gives the Board assurance that the Health Board will remain within its risk appetite and, as a result, achieve its objectives.*

5.6. The Health Board Executive Team will put systems in place to manage risk to an acceptable level within its agreed risk appetite levels. In setting such levels, the Health Board will take account of the degree of both and opportunity.

5.7. When risks are identified, the Executive Directors will recommend to the Board whether to tolerate or accept them. Executive Directors will provide on-going assurance to the

Board that existing controls are sufficient to mitigate risks to within the agreed tolerance levels, and will highlight where the cost of treating the risk is more expensive than the potential benefits to be realised.

5.8. Target risk ratings shall be set for all risks on the Datix Risk Management System. A target risk rating is the estimated residual risk following the application of reasonable mitigating controls.

5.9. The target risk rating is the lowest level of risk acceptable or tolerable for particular risks.

5.10. Some risks tolerance levels will require the approval of the Board or committees where relevant, particularly where the application of controls is restricted by external factors. Where this is the case, it will be outlined clearly in the BAF cover report, which is expanded on in section 6.

5.11. Risks that have reached the agreed target rating will also be treated as tolerated risks.

5.12. Risks should be accepted as tolerable only when the mitigation plan has been implemented as far as reasonably practical and there is assurance that controls are effective.

5.13. The Health Board regards risks that fall into the red 'high' category as significant and actions to control the risk must be taken immediately.

6. RISK APPETITE STATEMENT

6.1. The Health Board endeavours to establish a positive risk and safety culture in the organisation, where unsafe practice (clinical, managerial, etc.) is not tolerated and where every member of staff is committed and empowered to identify/correct/escalate system weaknesses.

6.2. The Health Board is committed to ensuring a robust infrastructure to manage risks from ward to board level, and where risks crystallise, to evidencing improvements are put in place.

6.3. The Health Board's intention is to *minimise* the risk to the delivery of quality services in the Health Board's accountability and compliance frameworks and maximise performance.

6.4. To deliver *safe, quality* services, the Health Board will encourage staff to work in collaborative partnership with each other and service users and carers to *minimise* risk to the greatest extent possible and promote patient well-being. Additionally, the Health Board seeks to *minimise* the harm to service users arising from their own actions and harm to others arising from the actions of service users.

6.5. The Health Board wishes to maximise opportunities for developing and growing its business by encouraging entrepreneurial activity and by being creative and pro-active in seeking new business ventures consistent with the strategic direction set out in the Health Board Strategy, whilst respecting and abiding by its statutory obligations.

Strategic Objectives	Risk Appetite	Risk appetite Statement
SO1: Improve physical, emotional and mental health **Failure to achieve 2022/23 savings target of £35m, resulting in a breach of our statutory financial duty** and well-being for all.	OPEN	The Health Board recognises that in order to provide outstanding care and patient experience there may be a need to accept a short-term impact on quality outcomes to achieve longer term rewards and innovations for our patients.
SO2: *Target our resources to people who have the greatest needs and reduce inequalities*	OPEN	The Health Board has an open risk appetite to explore innovative solutions to future staffing requirements, the ability to retain staff and to ensure the Health Board is an employer of choice.
SO3 *Respect people and their dignity*	OPEN	The Health Board is prepared to accept risk in relation to innovation and ideas which may affect the reputation of the organisation but are taken in the interest of enhanced patient care and ensuring we deliver our goals and targets.
SO4: *Work in partnership to support people (individuals, families, carers, communities) to achieve their own well-being*	SEEK	The Health Board recognises there may be an increased inherent risk faced with collaboration and partnerships but this will ultimately provide a clear benefit and improved outcomes for the population of Wirral.

SO5: *Improve the safety and quality of all services, whilst listening to people and learning from their experience*	SEEK	The Health Board is eager to accept the greater levels of risk required to transform its digital systems and infrastructure to support better outcomes and experience for patients and public.
SO6: *Support children to have the best start in life*	OPEN	The Health Board has an open risk appetite and is eager to pursue options which will benefit the efficiency and effectiveness of services whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements.

7. CORPORATE RISK REGISTER

7.1. The Corporate risk register (CRR) provides a framework for monitoring risks deemed signification to the delivery of corporate objectives set out within the annual plan.

7.2. The CRR is owned by the Risk Management Group, and will be subject to a bi-monthly review as a standing item, and risks with a current rating of 15 and above will be included.

7.3. Risks with a lower rating will be incorporated within divisional risk registers, and kept under review in order to ensure escalating risks are proactively identified.

7.4. The CRR will be reviewed regularly in order to ensure its completeness, alongside risks with a lower current risk rating.

7.5. A formal internal assessment of the CRR's completeness will be undertaken on a bi-annual basis and submitted to the Audit Committee for the purposes of providing assurance on :

7.5.1. The completeness of the clinical and corporate risk profile, when triangulated with significant issues for incorporation with the Annual Governance Statement

7.5.2. Whether any risks on the CRR require inclusion onto the Board Assurance Framework

7.5.3. Reviews undertaken to determine de-escalation of risks as well

7.5.4. Consideration has been given to significant risks arising from internal and external sources (as outlined in section 9 of this document)

7.6. As part of the process of monitoring the CRR, staff will be actively encouraged and empowered to raise any new or emerging risks as part of their day to day work, subject to independent verification by the lead Executive Director and Risk Management Team.

7.7. The CRR will be reviewed on the following frequency, within the Board and committee structure

Forum	Frequency	Role/Purpose
Risk Management Group	Bi-monthly	Assurance, and oversight of maintenance of document
Quality, Safety and Experience Committee	Bi-monthly	Assurance on the CRR in its capacity as the Risk Committee of the Board, taking into account assurances received from the work of the Risk Management Group
Audit Committee	Quarterly	Independent Scrutiny and Challenge of the risk management process
Performance, Finance and Information Governance Committee	Bi-monthly	Assurance and oversight of risks relevant to the Committee
Partnerships, People and Population Health Committee	Quarterly	Assurance and oversight of risks relevant to the Committee
Mental Health and Capacity Committee	Quarterly	Assurance and oversight of risks relevant to the Committee
Board	Annually	Year End assurance, taking into account detailed work undertaken by the Board's Committees

8. THE BOARD ASSURANCE FRAMEWORK (BAF)

8.1. An effective Board Assurance Framework gives the Board a simple comprehensive tool for effective and focused management of the principal risks to meeting its objectives.

8.2. It provides a structure for the evidence to support the Annual Governance Statement disclosure. It simplifies Board reporting and the prioritisation of action plans which, in turn, allow for more effective performance management.

8.3. The Board Assurance Framework provides the Board with a mechanism of identifying and assessing risks significant to the delivery of Health Board strategy, whilst evaluating the effectiveness of controls, and the monitoring of action plans.

8.4. The Board Assurance Framework (BAF) is based on six key elements:
  8.4.1. Clearly defined principal objectives aligned to clear lines of responsibility and accountability.
  8.4.2. Clearly defined principal risks with an assessment of potential impact and likelihood.
  8.4.3. Key controls by which these risks are being and can be managed.
  8.4.4. Quantification of the strengths and weaknesses of potential and actual assurances that the risks are being properly managed.
  8.4.5. Reports identifying those risks are being reasonably managed and objectives being met, together with the identification of any gaps in assurances and in control
  8.4.6. Action plans which ensure the delivery of objectives control of risk and improvements in assurances.

8.5. The BAF cover reports will be aligned to support assurances to support the Chief Executive's Annual Governance Statement Disclosure.

8.6. Specifically, BAF assurance reports to the Board will reflect:
  8.6.1. New risks added since the last meeting
  8.6.2. Changes in risk ratings
  8.6.3. Updates on delivery of action plans, at points in which they fall due
  8.6.4. Updates on external assurances, as a result of enhancing the visibility of evidence to support risk mitigations.
  8.6.5. Triangulation with any other items on the agenda, such as performance reports
  8.6.6. Recommendations for remedial actions that require detailed board review

8.7. *Lastly, the BAF reports will flag risks that require escalation to the Board in a timely manner.*

8.8. The BAF will be refreshed annually considering :

8.8.1. *Risks which may prevent the Health Board from achieving the Strategic Objectives will be set out in the Board Assurance Framework, and assessed annually.*

8.8.2. *At the end of each financial year, the Board will collectively review the BAF, to identify the risks significant to the delivery of the organisation's strategic objectives.*

8.9. Further new risks proposed for inclusion on the Board Assurance Framework will be added following the agreement of the Board as they arise.

8.10. Each risk in the BAF will be scored using the Health Board's Risk Scoring Matrix, and monitored in accordance with the frequency set out.

8.11. The Board Assurance Framework will be reviewed quarterly by the Health Board.

9. RISK MANAGEMENT DUTIES

9.1. Chief Executive

9.1.1. As Accountable Officer of the Health Board, the Chief Executive Officer has overall responsibility for maintaining a sound system of internal control that supports the achievement of the Health Board's objectives, whilst safeguarding public funds and assets

9.1.2. The Chief Executive will ensure that executive directors have appropriate access to annual training and education for risk management in healthcare to enable them to undertake their roles effectively.

9.1.3. The Chief Executive will ensure that there are robust arrangements for business continuity planning.

9.1.4. The Chief Executive is responsible for ensuring that the Health Board is administered prudently and economically and that resources are applied efficiently and effectively.

9.2. Executive Directors

9.2.1. The Executive Directors are accountable to the Chief Executive for all areas of risk and assurance in respect of areas in their remit, including the maintenance of live risk registers which are monitored regularly

9.2.2. Executive Directors are collectively accountable for risk management and ensuring risk management arrangements are embedded in their areas of responsibility, with specific roles outlined below:

9.3. Lead Director responsible for risk management

9.3.1. The Lead Director responsible for risk management has delegated overall strategic responsibility from the Chief Executive for the management of risk in the Health Board and is the Executive Lead Director for devising, implementing and embedding all risk processes throughout the organisation.

9.3.2. The Lead Director responsible for risk management will provide advice on risk management to the Executive Directors and Board, and will recommend the inclusion of risks on the Board Assurance Framework.

9.3.3. The Lead Director responsible for risk management will ensure the corporate risk register is reviewed monthly at the Risk Management Group, with remedial actions put in place to address non-compliance.

9.4. Board Secretary

9.4.1. As the Health Board lead for strategic risk, the Board Secretary is responsible for:

9.4.1.1. Drafting and refreshing the risk management strategy

9.4.1.2. Overseeing the process of implementing the strategy

9.4.1.3. Maintaining and updating the BAF, whilst ensuring timely submissions are made to the Board and Assurance Committees as appropriate

9.4.1.4. Ensuring the Annual Governance Statement requirements pertaining to risk management are met on an annual basis

9.5. Executive Director of Nursing

9.5.1. The Executive Director of Nursing will ensure nursing and allied healthcare staff comply with all safety and risk management procedures, providing

assurance on the management of risks related to their professional practice, liaising with professional bodies as required.

9.6. Executive Director of Finance

9.6.1. The Executive Director of Finance is also the Senior Information Risk Owner (SIRO) and has executive responsibility for the identification, scoping definition and implementation of an information security risk programme.

9.6.2. The SIRO oversees the development of an Information Risk policies and procedures; ensures that the Health Board's approach to information risk is effectively resourced and executed and provides a focal point for resolution of information risk issues.

9.6.3. The SIRO will act as an advocate for information risk on the Board and in internal discussions, and will provide written advice to the Accountable Officer on the content of the annual Governance Statement in regard to information risk.

9.6.4. The Executive Director of Finance has responsibility for ensuring that the Health Board operates within financial constraints and balances competing financial demands and overseeing the delivery of the internal audit plan and associated internal audit recommendations.

9.6.5. The Executive Director of Finance is accountable to the Board for the delivery of the financial plan and digital strategies, and for managing associated risk.

9.7. Executive Director of Workforce and Organisational Development

9.7.1. The Executive Director of Workforce and Organisational Development is responsible for ensuring risks deemed significant to the delivery of workforce objectives are met, with assurance reports feeding into the Workforce Assurance Committee, Board, and elsewhere as appropriate.

9.7.2. As Executive lead for Health and Safety, the Executive Director of Workforce and Organisational Development is responsible for ensuring the timely identification and mitigation of risks to Health and Safety

9.8. Executive Director of Integrated Clinical Services

9.8.1. The Executive Director of Integrated Clinical Services is responsible for ensuring the delivery safe and effective care whilst mitigating associated risks,

such as risks to delivery of targets being achieved. In discharging this duty the Executive Director of Integrated Clinical Services will ensure a robust divisional accountability infrastructure is in place in order to provide assurance that risks are being appropriately mitigated.

9.9. Executive Director of Public Health

9.9.1. The Executive Director of Public Health is responsible for ensuring the delivery safe and effective care within Population Health, Mental Health, Women and Children's services whilst mitigating associated risks, such as risks to delivery of targets being achieved. In discharging this duty the Executive Director of Public Health will ensure a *robust divisional accountability* infrastructure is in place in order to provide assurance that risks are being appropriately mitigated

9.10. Independent Members

9.10.1. Independent Members (IMs) have an important role in risk management, seeking assurance on the effectiveness of procedures and controls through constructive challenge and holding the Executive Directors and Senior Management to account. The role of IMs is not to manage individual risks, but to satisfy themselves that the Health Board's risk management arrangements are robust and fit for purpose.

9.11. All Staff

9.11.1. All staff have a responsibility to:

9.11.1.1. Familiarise themselves with and comply with Health Board Risk Management Policy and processes

9.11.1.2. Attend appropriate risk management training deemed necessary to enable them to undertake their duties

9.11.1.3. Mitigate risks over which they have control in their daily work

9.11.1.4. Proactively escalate concerns in instances where gaps in risk management training are identified, as soon as reasonably possible to their line manager.

9.11.1.5. Report breaches of compliance as outlined within the risks management strategy, whether by others or by themselves

10. GOVERNANCE ARRANGEMENTS FOR RISK MANAGEMENT

10.1. Health Board

10.1.1. The role of the Board includes the identification, treatment and monitoring of risks signification to the delivery of the organisation's strategic objectives, which is aided by the use of a Board Assurance Framework (BAF).

10.1.2. The BAF document has been established by the Board and will be reviewed on a Bi-Monthly basis.

10.1.3. **The Executive Director Team will** retain operational ownership and maintenance of the BAF. Its key elements include:

10.1.3.1. Identification of the principal risks that may threaten the achievement of Board identified strategic objectives

10.1.3.2. Identifying the design of controls to manage these principal risks

10.1.3.3. Setting out the arrangements for obtaining assurance on the effectiveness of key controls across all areas of principal risk

10.1.3.4. Identifying assurances and are gaps in controls and / or assurances

10.1.3.5. Instigating corrective plans where gaps in control have been identified

10.1.3.6. Dynamic risk management including a well-founded risk register

10.1.4. The Board is responsible for monitoring the internal control arrangements in each financial year to support the Annual Governance Statement Disclosure declaration.

10.1.5. As part of the delivery of this strategy, the Board will:

10.1.5.1. Ensure significant strategic risks are mitigated sufficiently within the risk tolerance levels in a timely manner and monitored through the BAF and the Board agenda

10.1.5.2. Assess and evaluate the appropriateness of risk tolerance levels set out in the risk tolerance matrix and formally agree any amendments.

10.1.5.3. Monitor significant risks via the BAF, whilst receiving assurance from Board committees, on the implementation of mitigating actions

10.2. Board Committees

10.2.1. Each Committee of the Board has specific responsibility for seeking on going assurance on the effectiveness of the arrangements for managing key risks.

10.2.2. The Board will review the effectiveness of each Committee annually to support the review of the system of internal control.

10.2.3. Board Committees all have responsibility for elements of the risk management system, with the Audit Committee independently assessing its effectiveness

10.3. Audit Committee

10.3.1. The Audit Committee supports the Board in reviewing the effectiveness of the system of internal control, through a structured annual work plan. The Committee will seek assurance that the Health Board's governance and risk management systems are fit for purpose, adequately resourced and effectively deployed.

10.3.2. Independent members of the Audit Committee will play a key role in the internal control assurance processes, by scrutinising the effectiveness of management actions in mitigating risks through regular reviews of the Health Board risk register.

10.3.3. To aid this assurance, the Committee's work plan incorporates a review of the organisation's risk management processes, and associated risk registers, from divisional to corporate level on a cyclical basis, to gain assurance that systems in place are effective.

10.3.4. The Committee will monitor action plans associated with the delivery of this strategy.

10.3.5. The Audit Committee will provide assurance to the Board on the effectiveness of the system of internal control through:

10.3.5.1. Regular monitoring of significant corporate and strategic risks on behalf of the Board

10.3.5.2. Monitoring of the implementation of the internal audit plan, and of associated internal audit recommendations, requesting further assurance on the management of risks identified from audits with limited assurance opinion

10.3.5.3. Formally reviewing the system of internal control annually taking assurances from Board Committees on management of detailed risks.

10.4. Quality, Safety and Experience Committee

10.4.1. The Quality, Safety and Experience (QSE) Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition the Committee will scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy

10.4.2. As the Risk Committee of the Board, the QSE Committee will meet six times a year and will review significant risks with a Health Board wide impact and the BAF at each meeting

10.4.3. As part of its role the QSE Committee will seek detailed assurance reports on significant risk areas identified through the aggregation of incidents, complaints, never events and claims

10.4.4. The Committee will report to the Board via a Chair's assurance report, with specific assurance given on the action plans to mitigate risks, as well as independent sources of assurance where possible.

10.4.5. The QSE Committee will review risks with a residual rating of 15-25, ***with a particular focus on risks to patient safety, quality and patient experience,***

taking into account risks identified through clinical and internal audit processes

10.4.6. Risks that fall below this threshold will be monitored by the Groups of the Committee, with assurance updates provide via a Chair's report. These groups will review and monitor progress against mitigation of key risks at each meeting on a bi-monthly basis.

10.4.7. As part of the implementation of this strategy the QSE Committee will:

10.4.7.1. Review assurances on learning and how it is embedded in divisions to manage risks. *The Committee will regularly review recurring themes from incidents, complaints, Regulation 28 coroner reports as well as serious incidents*

10.4.7.2. Request detailed reports on the top strategic risks as highlighted on the BAF, assuring to the Board via Committee Chair assurance reports

10.4.8. As part of its remit, the Committee has a responsibility to monitor the delivery of the Quality Improvement Strategy, Clinical Strategy and associated risks

10.5. Performance, Finance and Information Governance (PFIG) Committee

10.5.1. As part of the delivery of this strategy the Committee will:

10.5.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

10.5.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.5.1.3. Monitor the implementation of the:

- Digital Strategy
- Integrated Medium Term Plan
- Savings Plan
- Performance recovery plans and associated targets

10.5.2. And the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

10.5.3. The PFIG Committee will review risks with a residual rating of 15-25, with a particular focus on risks to performance, finance and information governance, taking into account risks identified through external and internal audit processes

10.6. Partnerships, People and Public Health (PPPH) Committee

10.6.1. As part of the delivery of this strategy the Committee will:

    10.6.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

    10.6.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.6.2. Monitor the implementation of the People Strategy, Living Healthy Staying Well, and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

10.6.3. The PPPH Committee will review risks with a residual rating of 15-25, with a particular focus on risks to Population Health, Transformation, people and partnerships, taking into account risks identified through external and internal audit processes

10.7. Mental Health Capacity Compliance Committee

10.7.1. As part of the delivery of this strategy the Committee will:

    10.7.1.1. Review significant corporate and strategic risks that fall in its remit as a standing agenda item

    10.7.1.2. Receive assurance on risks below this residual rating threshold from its groups, via Chair assurance reports

10.7.2. Monitor the implementation of key legislative requirements and the mitigations of associated risks, providing updates to the Board via the Committee Chair's assurance reports.

10.7.3. The MHCC Committee will review risks with a residual rating of 15-25, with a particular focus on risks to Population Health, Transformation,

people and partnerships, taking into account risks identified through external and internal audit processes

10.8. Risk Management Group

10.8.1. The Risk Management Group (RMG) will maintain operational oversight of the risk management systems and process, whilst ensuring they are fit for purpose and embedded across all areas of the Health Board in line with this Risk Management Strategy.

10.8.2. The Group will also maintain oversight of risks and providing scrutiny and oversight of the full Corporate Risk Register prior to review by Board Committees. The Risk Management Group will report to the QSE Committee, providing assurance on arrangements put in place by senior managers to proactively identify and mitigate risk. The RMG will also perform the following functions:

10.8.2.1. Review, scrutinise and challenge the effectiveness of proposed or current mitigations, and actions pertaining to risk register reports, including new risks that have been approved by Executive Directors for inclusion on the CRR/Tier 1.

10.8.2.2. Undertake deep dives and `check and challenge` of risks on the CRR including those that have been approved for the CRR/Tier 1 as well as challenge any change in risk scores that have been approved by Executive Directors and advice appropriately.

10.8.2.3. Receive assurance reports from the Head of Risk Management triangulating risks from other sources (such as clinical audit, never events, serious incidents, internal and external audits) and instruct the relevant services to ensure such risks are appropriately assessed and captured on their risk registers and escalated if applicable.

10.8.2.4. Review and scrutinise risk management performance reports, audits, the updated Risk Management Strategy and its associated procedural documents as well as any other risk management related reports and advise accordingly.

10.9. Executive Delivery Groups

10.9.1. The Executive Delivery Group Chair of the organisation have a duty to ensure a live processes ensure risks are identified proactively and robustly mitigated, escalating in a timely manner where appropriate.

10.9.2. The Executive Delivery Groups (EDGs) of the Health Board are:
- Population Health
- People and Culture
- Performance and Finance
- Quality

10.9.3. As part of the implement of this strategy, risk management will be a standing agenda item on the EDG agendas, and a record of appropriate action taken in relation to existing or new risks.

10.9.4. Each EDG Chair will ensure that a process is in place to ensure significant risks are escalated and mitigated in a timely and effective manner.

10.10. Local Quality, Safety and Governance Meetings

10.10.1. As part of the implementation of this strategy, all senior managers will put in place the necessary arrangements to maintain oversight of the proactive and effective management of risks through in place for good governance, quality, safety and effective risk management.

10.10.2. Senior managers will ensure monthly Quality and Safety or governance meetings are held, with a particular focus on monitoring and updating their risks, whilst enabling environment for bottom-up risk reporting with Services

and Departments under their remits routinely providing their risk register reports for review, scrutiny, assurance and oversight.

10.10.3. Through the implementation of this strategy senior managers will ensure a devolved accountability infrastructure is in place to maintain visibility of risks at all levels

10.11. Health and Safety Risks

10.11.1   Employers are required under the Management of Health and Safety at Work Regulations 1999, the Health and Safety at Work etc, Act 1974 and other pieces of legislation to protect their employees, and others, from harm.

10.11.2   Employers and employees thus have a duty of care to protect the health, safety and welfare of anyone who may be affected by their actions and/or omissions. Health and Safety risks, which arise within the context of occupational health and relation to assessment of hazards that could lead to the harm, injury, death or illness of a worker in a workplace.

10.11.3   Examples of Health and Safety risks include fall from height electrocution, water safety, confined spaces, construction, asbestos, COSHH, fire safety, slips, trips and falls , violence and aggression, work-related accidents and ill health.

11.   APPROACH TO RISK

11.1. Risk Identification

11.1.1. The risk management process is outlined in detail within the Risk Management Policy.

11.1.2. As part of the implementation of this strategy, the Health Board will put in place proactive and reactive approaches to the identification of risks, primarily through the risk assessment processes which assess the potential to cause any of the following:

11.1.2.1. Injury

11.1.2.2. Complaint

11.1.2.3. Litigation

11.1.2.4. Damage to the environment or property

11.1.2.5. Failure to maintain services and/or the quality of services provided by the Health Board,

11.1.2.6. Failure to meet national and organisational targets loss of reputation and financial loss etc.

11.2. Sources of risk identification

11.2.1. There are internal and external sources of risk:

11.2.1.1. Internal risks are identified, in the course of strategic and business planning, adverse incidents, complaints, claims, noncompliance with statutory duties and guidance, enquiries and clinical/nonclinical hazards identified for any Health Board activities.

11.2.1.2. External sources of risk are identified in the course of risk alerts, hazard warnings and recommendations received by the Health Board from a recognised external source – e.g. information from the Medicines & Healthcare Products Regulatory Agency (MHRA), HIW, National Institute for Clinical Excellence (NICE), Health and Safety Executive (HSE), inquiries and other bodies. These will be communicated immediately and applied as appropriate in the Health Board.

11.2.2. In implementing this strategy, the Health Board's goal is to ensure that the effect of any risk is reduced to an acceptable level or negated completely. In practice, this will be executed by using internal and/ or external advice to decide on the most appropriate options to treat risk and by sharing best practice and learning from other organisations.

11.2.3. Risk treatment (means of addressing risks) can be broken down into the following:

11.2.3.1. Avoid - some risks may only be managed by terminating the activity (i.e. avoiding the risk by not undertaking the activity that could lead to the risk occurring)

11.2.3.2. Control - preventative controls are measures currently in place when a risk is identified to control the risk i.e. directive controls or policies and processes, clear labelling of packages, checking a patient's identity before a procedure. If existing controls are shown not to be adequate, e.g. gaps are identified, an action plan should be produced to ensure the risk is mitigated with additional controls. Action plans will be approved initially by a division as per the risk reporting arrangements

11.2.3.3. Transfer - for some risks, the best method of control is to transfer them to a third party to reduce the exposure to the Health Board or because another organisation will manage the risks more effectively e.g. financial risks can sometimes be transferred by effecting insurance). However, this process needs to be carefully managed and internally validated to ensure the Health Board's exposure is minimised.

11.2.3.4. Tolerate - the exposure to the risk may be tolerable/accepted without any further controls.

11.2.4. In assessing any mitigating actions associated with a risk there should also be an assessment of the impact of such actions.

11.2.5. All managers have authority for risks in their areas of responsibility in line with their resources available to them to eliminate or control the risk. Where the manager does not have suitable or sufficient resources they should refer the issue to their line manager.

12. RISK MANAGEMENT PROCESS

12.1. The Risk Management process is summarised in figure 4 below, and incorporates a proactive and reactive approach.

12.2. Risk assessment is an iterative process and all risks will be periodically reviewed and re-assessed in view of contextual changes.

12.3. Re-assessment is undertaken proactively at intervals proportionate to the risk magnitude and risk appetite as well as reactively in response to anticipated or known changes.

12.4. The Health Board will explore its risk appetite for significant risks through a review of the Board Assurance Framework, Health Board risk register and evidence considered as to whether residual risks are acceptable or not.

12.5. All strategic risks will be reviewed on a bi-monthly basis by the Executive Directors who confirm their management through the content of the BAF in preparation for presentation to the Board.

12.6. All moderate and significant risks (current risk score 9-25) will be reviewed by the Executive Directors who will confirm their approach to mitigation through the content of the Health Board risks register operationally at Health Board Management Board, and also the Risk Management Committee on an alternate basis in preparation to the Board for their consideration

12.7. All lower level risks (with a current risk score less than 9) are reviewed and managed locally by the Divisional management in their Governance meetings.

12.8. Risks which are not considered acceptable at a local level will be escalated as appropriate, and managed through strategic and operational change or transferred (e.g. by contracting out) leaving acceptable (and opportunity) risks.

12.9. Such risks are managed and mitigated through the Risk Management processes and retained risks are recorded and reviewed through the Health Board's risk registers.

Figure 4: Risk Management process

Risk Identification
- Regulatory requirements
- Quality Metrics
- Quality impact assessment
- Early warning trigger tool
- Information Security
- Incident Claims and complaints (
- Financial Risk
- Clinical Risk
- Fraud Risk
- Clinical Audit
- Strategic and Corporate Objectives

Risk Assessment
a)   Assess severity of risk
Ascertain likelihood and impact of risk
= Gross Risk
b)   Identify and grade controls in place
= Risk Mitigation
c)   Reassess severity of net Risk
= Current Risk

Risk Acceptable?

Risk Monitoring
- Manage locale and review regularly in divisional meetings
- Performance monitoring of divisions at Health Board level

Risk Evaluation
- Identify further controls
- Validate proposed controls
- Assign Lead
- Set implementation date
- Set review dates
- Identify and articulate
- Assess resources required

Corporate Risk Register level monitoring

Risk Monitoring
- Risk monitoring by Executive Director
- Monitor implementation of risk mitigation plans
- Provide monthly update to Risk Management Committee
- Escalate risks in accordance with risk tolerance matrix
- Monitor progress against residual risk

Communicate risk to Stakeholders
Internal
- Local Staff
- Managers
- Contractors
- Committees
External
- Commissioners

Review using key indicators
- Feedback from staff
- Incidents
- Complaints
- Claims
- Performance Reports

Renew Completed Actions
- Re – assess and re – grade residual Risk
- Accept sign – off residual Risk
- Set review date

Risk Acceptable?

Risk Monitoring
Manage and review at Executive Director Level at Risk Management Group

13.   PROACTIVE RISK MANAGEMENT APPROACH

13.1. Internal inspections/reviews and assessments

13.2. Risks will be identified, assessed and mitigated through internal inspections or reviews, e.g.:

13.2.1. Statutory/Regulatory gap analysis or internal self-assessment

13.2.2. Delivery of clinical audit plan

13.2.3. Health, safety and fire inspections

13.2.4. Internal infection control visits

13.2.5. Health Inspectorate Wales peer reviews

13.2.6. Internal audit reviews

13.2.7. Internal assessment of risks

13.3. Risks identified will be escalated in accordance with the thresholds set out in the Risk Tolerance Matrix.

13.4. Quality impact assessment tool

13.4.1. A Quality Impact Assessment Tool provides a consistent approach to ascertaining the impact on quality associated with service changes.

13.4.2. It is intended to support quality governance by assessing the impact of CIPs and service change on quality.

13.4.3. It involves an initial assessment (stage 1) to quantify potential impacts (positive or negative) on quality from any proposal to change the way services are delivered. Where potential negative impacts are identified they should be risk assessed using the risk scoring matrix to reach a total risk score.

13.4.4. Where a negative impact score of 9 and above is identified a detailed quality impact assessment is required, with associated mitigations.

13.4.5. The Quality Assurance Committee will monitor action plans associated with a negative impact score of 15 and above, and also action plans resulting in a

positive impact. Quality impact assessments with an adverse impact will be generated onto the Health Board risk register and monitored in line with other quality risks

13.4.6. Risks will be escalated in accordance with levels set out in the *risk tolerance* matrix.

13.5. Learning from external sources

13.5.1. The Health Board will put in place a Development Programme that incorporates learning from various sources, such as coroner interventions and inspections by the Health Inspectorate Wales for example.

13.5.2. Where appropriate and relevant, the Board will delegate the monitoring of action plans to specific Committees, receiving assurance through Chair Assurance reports.

13.5.3. The Health Board ensures that there is a systematic approach to the analysis of incidents, complaints and claims to enable learning and improvement as part of the implementation of this strategy.

13.5.4. The Executive Directors will instigate a robust process to ensure that risks identified from learning are added to the corporate risk register, where appropriate, with associated action plans which are reviewed regularly by the Risk management Group.

13.6. Early Warning Trigger Tool

13.6.1. The Health Board will develop an Early Warning Trigger Tool (EWTT) with a set of automatically weighted indicators (with a possible maximum score of 50) which taken together indicate how well a ward is functioning, and provide an early warning, pre-empting more serious concerns and enabling action before things go wrong.

13.6.2. The output of the EWTT enables ward managers and Divisional directors to benchmark the overall risk on their wards with others, resulting in the rapid identification of remedial action

13.6.3. The EWTT provides robust and reliable information from 'Ward to Board' offering the Health Board further assurance of the quality of care specifically at an individual clinical team level.

13.6.4. The EWTT will also be adapted for use in non-clinical areas applying 'early warning' metrics such as sickness absence, freedom to speak up issues, never events, near misses

13.6.5. The table summarises the risk escalation process based on ranges of EWTT scores:

Score Analysis Guide	Early Warning Trigger Tool score
Executive Team monitoring and Health Board escalation and assurance	40-50
Health Board-wide Performance monitoring , Executive Director monitoring and Quality Assurance Committee escalation and assurance	30-40
Divisional Director and Health Board-wide Performance Executive Committee escalation	20-30
General Manager escalation	10-20
Service /Ward Manager escalation	0-10

14. REACTIVE RISK MANAGEMENT APPROACH

14.1. As part of delivering this strategy, the Health Board will identify risks arising from serious incidents, claims, complaints and incidents and form action plans to reduce risks to a tolerable level.

14.2. The Health Board operates a fair, Just culture to ensure staff feel able and confident to report events or concerns.

14.3. Risks arising from complaints, Incidents and near misses rated 9 or above ('amber' or 'red') using the Risk Scoring Matrix will be entered on the Health Board Risk Register

and escalated in accordance with the Health Board's risk escalation process as articulated in the risk tolerance matrix

14.4. Claims scored using the Health Board's Risk Scoring Matrix and those rated 9) or above) will be entered on the Health Board Risk Register and are escalated in accordance with the Health Board's risk escalation process.

14.5. The Lead Director responsible for risk management will ensure a process is in place to review reports produced by Internal and External Audit with an audit opinion of limited assurance ensuring risks are identified and placed on the risk register as appropriate.

15. REGULATORY COMPONENTS OF RISK MANAGEMENT

15.1. In delivering this strategy the Health Board will consider the following aspects of statutory compliance, and the management of associated risks.

15.1.1. Health and Safety Legislation

15.1.1.1. The Health Board will discharge its statutory responsibilities under the EC framework directive (89/91/EEC) and the Management of Health & Safety Regulations 1992 (Amended 1999) to 'evaluate the risk to the safety and health of workers and anyone else who may be affected by its activity but not in its employment'.

15.1.2. Health Inspectorate Wales

15.1.3. Statutory Annual Governance Statement Disclosure

15.1.3.1. The Health Board will put in place robust arrangements to comply with requirements from the Annual Reporting Manual in relation to the production of an annual Governance statement disclosure which is assured by an effective risk management system.

15.2. Monitoring the Implementation of this Strategy

15.2.1. The implementation of this strategy will be monitored by:

15.2.1.1. Routine monitoring of the risks by the Quality Safety and Experience Committee, and independent assurance updates to the Audit Committee

15.2.1.2. The Health Board's progress against its strategic and corporate objectives.

15.2.1.3. Assurance from internal and external audit reports that the Health Board's risk management systems are being implemented.

15.2.1.4. Annual updates to the Board as part of the year-end review.

15.2.1.5. *An external review of governance and leadership every three years in line with the UK Corporate Governance Code provisions.*

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

PARTS A (Screening – Forms 1-4) and

B (Key Findings and Actions – Form 5)

For:	RM01 – Risk Management Strategy
Date form completed:	Originally completed 02/09/2021
	Reviewed and minor amendments June 2022

PARTS A: SCREENING and B:
KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A   Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	RM01 – Risk Management Strategy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Health Board aims to provide a structured, comprehensive, and coherent framework to support staff in identifying, assessing and managing risks arising from its business activities, as the effective management of risks is an inherent part of its approach to continuous learning, improvement and good governance. RM01 – Risk Management Strategy provides a framework and structure for the consistent management of both operational and strategic risks, as drivers for better decision-making and the provision of high quality, personalised, patient-centred care, and enhanced experience.
3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	Board Secretary
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	Board Assurance Framework Health and Safety Policy (HS01) Risk Assessment Guidance (HS03) Concerns Policy and Procedure (PTR01 and PTR01A) Datix Risk Register – Procedure and User Guide (RM02) Associated Risk Management Policies, Procedures, and Guidance
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	The Board and all employees.

Part A   Form 1: Preparation

Please answer all questions

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	The Corporate Risk Team launched an initiative to train 1000 staff across the Health Board in risk management for 2021/22, with various training slots advertised on the intranet and staff informed and encouraged to book. The plan is for all staff (including Board Members) in the next few years to receive training and/or refresher in risk management that is appropriate to their roles and responsibilities, however it is difficult for managers to find time to release staff from clinical duties to attend the training. Plans include the addition of a short version of Risk Management/Awareness Training into the Health Board's Corporate Induction Pack for new starters.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The Strategy describes the Health Board's approach to risk management as proactive, integrated, enterprise-wide and informed by an open and transparent culture in which staff feel empowered and confident to raise and discuss risks without fear, to engage staff across the entire organisation in exploring risk management as a tool for better decision-making and in achieving the objectives of the Annual Operational Plan 2021-22. The Strategy sets out the Health Board's Risk Appetite Framework, with a proactive, inclusive, and enterprise-wide approach to risk management.

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

Please answer all questions

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

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

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

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

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

Part A

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

Please answer all questions

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

Part A

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

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. For the definitions of each characteristic please click here					
	Yes	**No**	**(+ve)**	**(-ve)**		
Age		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Disability		No	+ve		Whilst the Strategy does not discriminate, the assessment has highlighted the need for, along with all other Health Board documentation, availability in a format to address any visual impairment disabilities, including colour blindness, and also, potentially, dyslexia.	This assessment highlighted that for those with visual impairment disabilities, additional support may be required – i.e. document transcription and additional support. With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column in working documents. In terms of dyslexia, a number of Health Board resources are

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

Please answer all questions

						available to support staff as a mitigating action.
Gender Reassignment		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Pregnancy and maternity		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Race		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Religion, belief and non-belief		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Sex		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Sexual orientation		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	
Marriage and civil Partnership (Marital status)		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	

Part A

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

Socio Economic Disadvantage		No	+ve		The Strategy does not discriminate – it sets out an inclusive, enterprise-wide approach to risk management.	

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

Please answer all questions
Human Rights:

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

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

UN Convention on the Elimination of All Forms of Discrimination against Women

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	No	(+ve)	(-ve)			
	No				The Strategy does not impact upon people's Human Rights – it sets out an inclusive, enterprise-wide approach to risk management.	

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

Please answer all questions
Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language		No	+ve		Whilst the Strategy does not discriminate, as with all Health Board documentation, the assessment has highlighted the need for availability in a Welsh language format.	The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.
Treating the Welsh language no less favourably than the English language		No	+ve		Whilst the Strategy does not discriminate, as with all Health Board documentation, the assessment has highlighted the need for availability in a Welsh language format.	The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	The Strategy underwent Health Board consultation, approval and ratification, involving those responsible for Equality Impact Assessment.
Have any themes emerged? Describe them here.	One of the Board members recommended the consideration "of staff who may be colour blind (RAG ratings) and anyone with dyslexia".
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	This assessment highlighted that for those with visual impairment disabilities, additional support may be required – i.e. document transcription and additional support. With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column in working documents. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action.

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	RM01 – Risk Management Strategy

2. Brief Aims and Objectives: (Copy from Form 1)	The Health Board aims to provide a structured, comprehensive, and coherent framework to support staff in identifying, assessing and managing risks arising from its business activities, as the effective management of risks is an inherent part of its approach to continuous learning, improvement and good governance. RM01 – Risk Management Strategy provides a framework and structure for the consistent management of both operational and strategic risks, as drivers for better decision-making and the provision of high quality, personalised, patient-centred care, and enhanced experience.

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes ☐	No ☒

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes ☐	No ☒
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales - Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/	Yes ☒	No ☐

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes ☐	No ☒
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes ☐	No ☒
	The Strategy states that for those with visual impairment disabilities, document transcription and support are available. With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action. The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes ☐	No ☒
	How is it being monitored?	The Health Board will undertake regular Risk Management Self-Assessments via the Risk Management Group, to measure the effectiveness of risk management arrangements across its services.
	Who is responsible?	The Risk Management Team and the Risk Management Group.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	What information is being used?	Annual internal audits, Snapshot Audits and/or an annual health check of risk management culture, using agreed Key Performance Indicators (KPIs).
	When will the EqIA be reviewed?	In line with the Strategy review cycle of business.

7. Where will your policy or proposal be forwarded for approval?	Audit Committee.

Part B   Form 5: Summary of Key Findings and Actions

Please answer all questions

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Justine Parry	Assistant Director of Information Governance and Risk, supported by the Head of Risk Management and Assurance and the Interim Risk Project Manager
	Molly Marcu	Board Secretary
	Justine Parry	Assistant Director of Information Governance and Risk
	Molly Marcu	Board Secretary
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No potential negative impacts identified, therefore no further actions required.		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	No changes required.		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	Already in place. The Strategy states that for those with visual impairment disabilities, document transcription and support are available. In terms of dyslexia, a number of Health Board resources are available to support staff as a mitigating action. The Health Board's Translation Service is freely available to those who would like a Welsh language version of the Strategy.		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column for all associated risk management materials as these are updated, going forward.	Head of Risk Management and Assurance.	As associated documents are updated.
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	With colour blindness identified as a potential difficulty in understanding any RAG ratings, a letter (R, A, G) will be added to the box or column for all associated risk management materials as these are updated, going forward.	Head of Risk Management and Assurance.	As associated documents are updated.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 05.07.2022
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Quality and Performance Report to 31st May 2022 3.3/QS22.213
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill Executive Director of Finance
Awdur yr Adroddiad Report Author:	Mr David Vaughan Head of Performance Assurance
Craffu blaenorol: Prior Scrutiny:	The data and information in this report has been scrutinised by the Director of Performance
Atodiadau Appendices:	None

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

| Please tick as appropriate |

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

Sefyllfa / Situation:

Delivery Measures

This report includes key indicators from the NHS Wales Delivery Framework 2021-22. The Executive Summary is included within the Report.

Cefndir / Background:

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

The Executive Summary pages of the Q&P sets out performance against the key measures contained within the 2021/22 Welsh Government National Delivery Framework.

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

Asesiad / Assessment & Analysis

Strategy Implications

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

Options considered

Not Applicable

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

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

Legal and Compliance
This report will be available to the public once published for Quality, Safety & Experience Committee

Impact Assessment
The Report has not been Equality Impact Assessed

Quality & Performance Report

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

Quality, Safety & Experience Committee

Data up to 31st May 2022
Presented on 5th July 2022

Title	Page	Title	Page
Cover	1	Quadruple Aim 2: Adult Mental Health	15 to 18
Table of Contents	2	Quadruple Aim 3: Quality	19 to 24
About this Report	3	Quadruple Aim 4: Mortality and Timely Interventions	25 to 28
Summary Dashboard	4	Additional Information	29
Executive Summary	5	Quadruple Aim 2: Charts - : Children's & Young Adults Mental Health Services (CAMHS)	30
Quadruple Aim 1: Improved population health and Wellbeing	6 & 7	Quadruple Aim 2: Charts – Adult Mental Health	31 & 32
Quadruple Aim 2: Better Quality and more accessible healthcare	8	Quadruple Aim 3: Charts – Sepsis Six Bundles	33
Quadruple Aim 2: Infection Prevention & Control	9 to 11	Charts – Impact of COVID-19 on Activity	34 to 37
Quadruple Aim 2: Children's & Adolescent Mental Health Services (CAMHS)	12 to 14	Further Information	38

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

Report Structure

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

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

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

Performance Monitoring

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

Performance has improved over the last 6 months

Performance has got worse over the last 6 months

Performance remains the same

Ongoing development of the Report

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

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

Summary Dashboard

Number of New Never Events: Apr-May 2022 **0**

Cumulative Rate per 100,000 S.Aureus: **31.48**

**CAMHS – Assessed within 28 Days: 25.0%
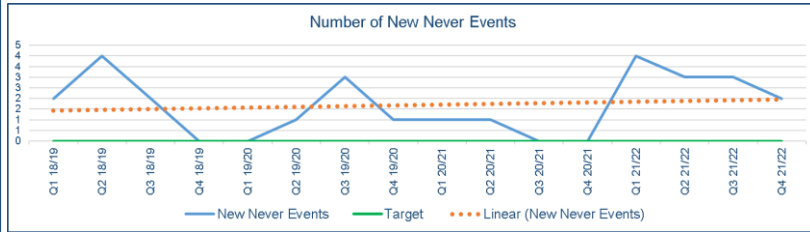
Immunisation - 6 in 1 Hexavelant: Q4 201/22 **94.63%**
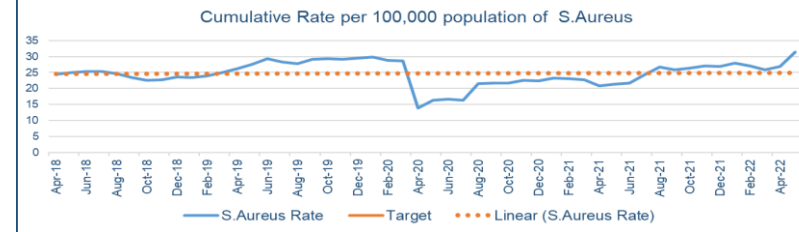
Cumulative Rate per 100,000 C.Difficile: **36.58**
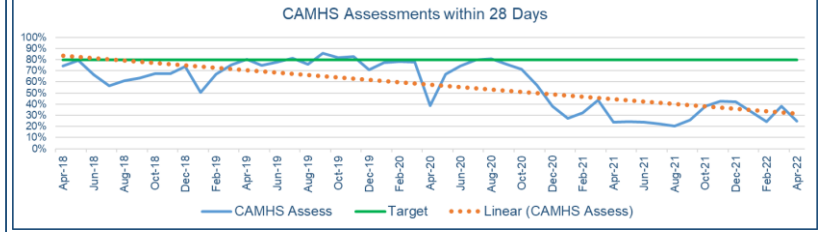
**CAMHS – Therapy within 28 Days: 18.18%

Immunisation- 2 doses MMR by 5: Q4 21/22 **97.05%**

Cumulative Number of MRSA: **3**
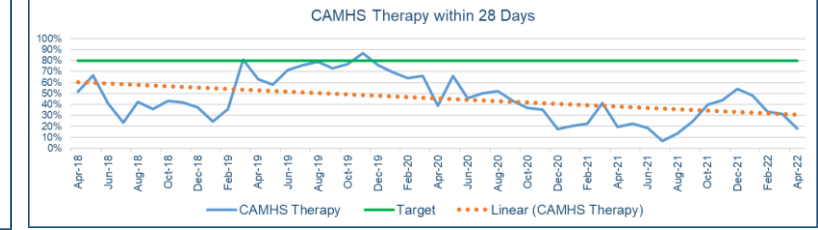
Neurodevelopment within 26 Weeks: **43.02%**

**Adult MH Assessed within 28 Days: 63.20%

Cumulative rate resets on the 1st of April each year

**Adult MH Therapy within 28 Days: 77.83%
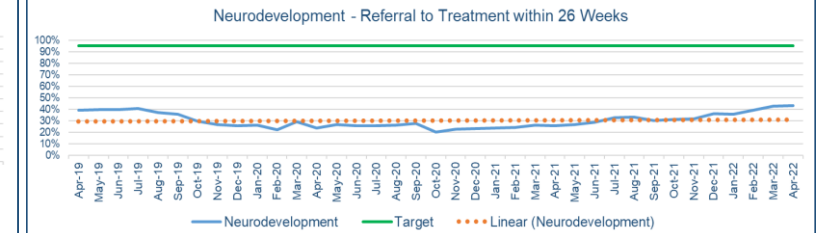
Adult Psychotherapy within 26 Weeks: **69.57%**

***Mental Health Measures reported 1 month in arrears*
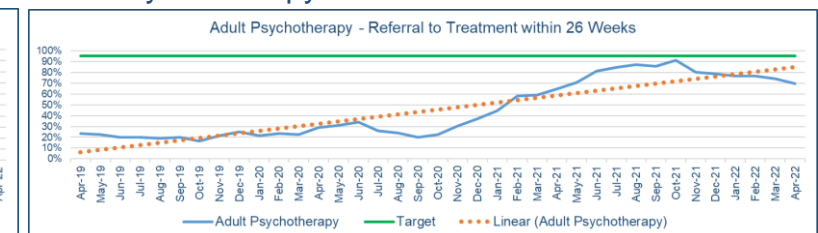
.The Committee is asked to note the following:

Quadruple Aim 1:Prevention
Despite the impact of the COVID-19 pandemic on most planned care services, it is encouraging to see that our immunisation of children programmes have continued to deliver throughout Quarter 4, 2021/22 at 94.63% of eligible children receiving 6 in 1 Hexavalent and 97.5% of eligible children receiving 2 doses of MMR vaccinations by age 5.

Quadruple Aim 2: Infection Prevention
Over the past 12 months, the cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population has increased at an all Wales level. This is in contrast to the position in BCUHB, which has seen continuous improvement in E.coli, Aureus bacteraemia and C Difficile rates per 100,000 population over the same period.

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

Quadruple Aim 2: Mental Health
For adult mental health services there was a dip, as expected, in performance compared to last month, with percentage adults assessed within 28 days of referral at 61.99%. This was due to an increase in referrals in March and issues with capacity in East,

which has a waiting list larger than West and Central combined. The number of patients starting therapy within 28 days of assessment has fallen below the 80% target at 77.83%.

Performance remains poor against the targets for the rate of children assessed within 28 days of referral, at 25%, and starting therapy within 28 days of assessment at 18.18%.

The consistent improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy has started to fall at 69.57% in May 202, still significantly higher than the low of 20.1% in September 2020.

Whilst the number of patients experiencing delayed transfer of care (DToC) within our mental health has improved slightly at 15 in May 2022 (compared to 18 in March 2022), the length of stays has fallen to 696 (compared to 1,125 in March 2022). The service is working to resolve issues that lead to DToC and it is expected that the number and length of DToCs will continue to fall over the coming months.

Although improving, performance against the 26 Week target or children awaiting neurodevelopment assessment remains poor at 43.02%.

Quadruple Aim 3: Quality & Safety
There were no new Never Events reported in April or may 2022.

The percentage closure rate of complaints managed under PTR < 30 working days (target 75%) - 60% May 2022. Whilst not reaching the set target the process is currently stable and delivering at around 60% compliance for the last 5 months. This is a sustained improvement compared to previous years, where performance has been as low as 30%. This reflects the learning from incidents and focus upon timely responses.

Quadruple Aim 4: Mortality and Timely Interventions
Crude Mortality (under 75 years old) has decreased to 0.98%. The mortality rate for BCU remains lower than the Wales.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments. Work is ongoing to resolve this.

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 lives. 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.

Period	Measure	Target	Actual	Trend
Q4 2021/22	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1*	>= 95%	94.63%	↓
Q4 2021/22	Percentage of children who received 2 doses of the MMR vaccine by age 5*	>= 95%	97.05%	↑
Q3 2021/22	Percentage of adult smokers who make a quit attempt via smoking cessation services**	>= 5%	2.23%	↑
Q3 2021/22	European Standrdised rate of alcohol attributed hospital admissions for indivudals resident in Wales	Reduce	357.6	→
Apr 22	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged under 18 years)*	>= 90%	93.30%	↓
Apr 22	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)*	>= 90%	86.51%	→

Period	Measure	Target	Actual	Trend
Q4 2021/22	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	Improve	74.10%	→
2020/21	Percentage of babies who are exclusively breastfed at 10 days old	Improve	36.10%	↑
Mar 22	Cumulative uptake of the influenza vaccination among 65 and Over this season	75%	79.80%	N/A
Mar 22	Cumulative uptake of the influenza vaccination among Under 65 this season	55%	51.00%	N/A
2021/22	Uptake of the influenza vaccination among Pregnancy	75%	87.00%	N/A
2021/22	Cumulative uptake of the influenza vaccination among Staff this season	60%	72.10%	N/A

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.

Quadruple Aim 2: Infection Control Measures

Period	Measure	Target	Actual
May 22	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	<= 67	68.06
May 22	Cumulative number of laboratory confirmed E-Coli cases	N/A	80
May 22	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	<= 20	27.98
May 22	Cumulative number of laboratory confirmed S.Aureus cases	N/A	37
May 22	Cumulative number of laboratory confirmed C.Difficile cases	N/A	43

Period	Measure	Target	Actual
May 22	Cumulative rate of laboratory confirmed C.Difficile cases per 100,000 population	<= 25.00	36.58
May 22	Cumulative number of laboratory confirmed MRSA cases	0	3
May 22	Cumulative number of laboratory confirmed MSSA cases	<= 40	34
May 22	Cumulative number of laboratory confirmed Klebsiela cases	<= 107	19
May 22	Cumulative number of laboratory confirmed Aeruginsoa cases	<= 28	7
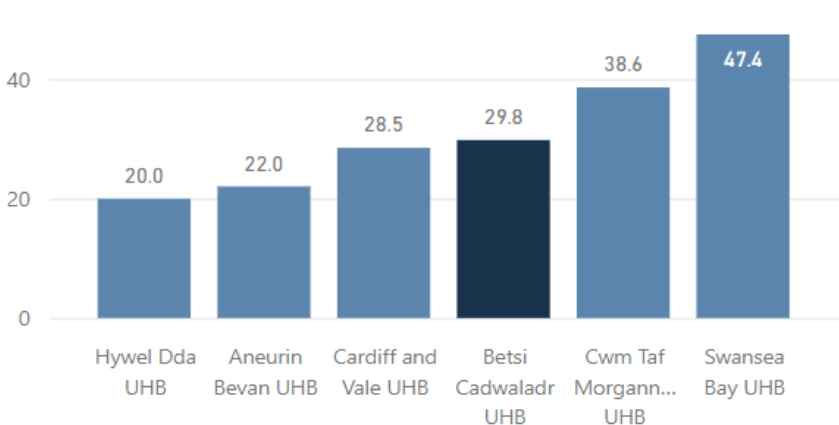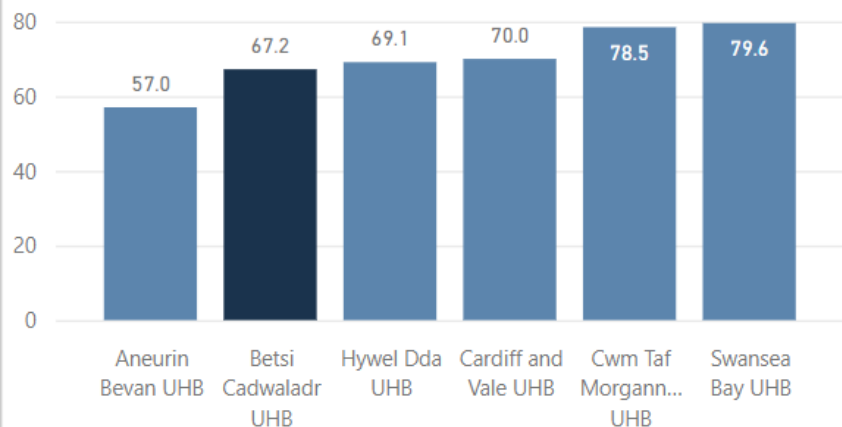
What are the key issues/ drivers for why performance is where it is?

- BCUHB has seen an increase in the number of C.Difficile infections and staphylococcus aureus bacteraemia infections in April and May, but with just 2 months data it is difficult to draw conclusions from this year's comparison data with other Health Boards.

What actions are being taken to improve performance and by who?

- 72 hour patient incident reviews are carried out on all alert organisms: good practice/learning is identified and shared at local and pan-BCU infection group meetings.
- Common issues identified are being used as the focus for the Safe Clean Care - Harm Free campaigns this year and Quarter 1 initiatives have launched.
- In relation to C.Difficile: several of the infections this year appear to be relapses so further work is being undertaken to review the data, genotypes and antimicrobial prescribing and will be fed back in August. Also a retrospective audit is being carried out to explore C.Difficile trends within cancer patients.

When performance is going to improve by and by how much

- BCU aims to achieve targets by March 2023.

What are the risks to this timeline?

- IP Risk Assessment Number 4241 'Inability to deliver timely IP services due to limited capacity', scoring 15.
- Decontamination Risk 4325 'Potential that medical devices are not decontaminated effectively so patients may be harmed', scoring 16.
- Challenges with domestic capacity and cleaning.
- There are insufficient single rooms with appropriate en-suite facilities to meet requirement for patient isolation (acute and community hospitals).
- Poor compliance with antimicrobial stewardship in several areas.
- As COVID measures are de-escalated, other organisms are emerging as a new issue, including TB risk in Ukrainians and Monkeypox.
- Engagement required by clinical staff to make changes to practice.

What are the mitigations in place for those risks?

- Actively recruiting to vacant posts in the IP team, using IP Champions to promote IP, preparing a business case for expanding the current team, designing a development programme for existing IP nurses and promoting the Bangor University IP education programme amongst non-IP staff.
- Shared Services Partnership carried out a review in May of key decontamination facilities at BCU with a report expected in July, outlining priorities for action.
- The Domestics recruitment programme is progressing and the current domestic resource is being prioritised e.g. to outbreak areas, with daily input from IP. Hypochlorous acid is being rolled as a safer and quicker alternative to HPV. Other new innovations are being explored including a trial of a UVC air purifier in the West.
- A new SOP and 'hierarchy of isolation tool' has now been launched to support best use of side rooms supported by advice from IP on prioritisation.
- To promote appropriate use of antibiotics there is continued focus on 'Start Smart then Focus' audits, Antimicrobial Steering Groups, pharmacy support to wards and microbiology ward rounds in place. A new Antibiotic Resistance Working Group has been established and is to meet monthly. An antibiotic resistance dashboard has also been developed to support Clinicians and will highlight antibiotic resistance patterns.
- The IP team keep clinical staff up to date and remain alert and flexible in their response to new challenges and changes to guidance.
- IPC Champion training sessions restarted and additional support provided to Local IP Groups to improve engagement. Also launched Plan-on-a-page for IP Group.

Quadruple Aim 2: Children & Adolescent Mental Health Services

Frequency	Measure	Target	Actual	Trend
Apr 22	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	43.02%	⬆
Apr 22	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral*	>= 80%	25.00%	⬇
Apr 22	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment*	>= 80%	18.18%	⬇

* Reported 1 month in arrears

Frequency	Measure	Target	Actual	Trend
2020/21	Rate of hospital admissions with any mention of intentional self-harm from children and young people (aged 10-24 years) per 1,000 population	Improve	5.14	⬆

* Reported Annually - Published April 2022

Quadruple Aim 2: Children & Adolescent Mental Health Services

What are the key issues/ drivers for why performance is where it is?
- Increased in demand for Mental Health Assessment; there has been an increase of 5% when compared to 2019/20 pre-pandemic levels, referrals increasing further during the latter part of Q3 and during Q4. Impacted significantly on the waiting list backlog
- Increased sickness / Covid-related absences during last quarter impacting on core capacity to deliver assessment and interventions
- Requirement to clear backlog of patients via internal and external commissioned activity to support ongoing improvement in terms of MHM delivery of target impacting on numbers seen within 28 days. Performance at end of April 25% for assessment and 18% for interventions. Unvalidated position for May indicates 25% for assessment and 31% for intervention. Position against trajectory is on track, with significant decrease in numbers waiting for assessment over 28 days.
- Diversion of core service capacity to increase resource for crisis and eating disorder service capacity noting the increased demand for both elements of the service nationally.

What actions are being taken to improve performance and by who?
- Contract being agreed with private providers, work ongoing to ensure maximisation of capacity with private providers to support improvements.
- CAMHS Regional Performance Recovery Plan submitted to EMT for IQPD meeting with WG/DU. Monitoring of performance against improvement trajectory and recovery planning is ongoing across all teams through the established Regional CAMHS Performance Delivery Group with escalation to Assistant Area Directors via Strategic Improvement & Development Group for oversight.
- A Performance Management Framework is being developed to ensure increased clarity of KPIs, responsibilities and accountability.
- Choice and Partnership Approach (CAPA) framework continues to be a priority across the region to inform team job planning and throughput for planned care core service..
- Additional 2022/23 WG funding bids submitted across the service to ensure adequate resources for sustained delivery against performance. Emphasis on early intervention and prevention services to improve the early help offer within schools and primary care, manage demand into specialist services and increase capacity within core services

When performance is going to improve by and by how much
- Trajectories and recovery plans for 2022/23 have been developed with a plan to reduce total numbers waiting over 28 days prior to the end of March 2023 across all areas to support delivery of MHM Part 1 targets by year end.

What are the risks to this timeline?
- Increased sickness absences across teams
- Should current vacancies and additional posts not be recruited to this will affect overall service capacity
- Increased demand on services, in terms of number of referrals received, acuity and complexity of cases

What are the mitigations in place for those risks?
- Development of workforce plan and support by Just-R recruitment agency
- Monitoring through area based weekly capacity and demand meetings in teams to ensure escalations are in place through TI Access work stream and area teams

What are the key issues/ drivers for why performance is where it is?

- Our core capacity to start new routine assessments continues to remain affected by a variety of factors that include clinical accommodation and increasingly due to clinical staff turnover issues.
- The gap between Core capacity and demand is significant and continues to require the development and implementation of a service workforce improvement and development plan which is in progress; funding is essential to make the impact required.
- The requirement to use further external providers going forward remains likely in order to meet demand, although this does require careful consideration due to some unintended consequences we are now seeing. Although the areas are now beginning to send some referrals of 26 weeks and less to the external provider, we are now reviewing the waiting list to ensure equity of access i.e. for those with welsh language requirements, or children with complex needs who do not always meet the provider's referral criteria.

What actions are being taken to improve performance and by who?

- Recruitment continues for additional management support – in the form of a ND regional programme manager and Clinical Transformational Lead.
- Identified backlog of assessments commenced during the pandemic are near completion,
- External Provider has been continued to the end June 2022 – for an additional 500 assessments
- Approval to utilise the £1.4 m in the IMTP is being confirmed via ET and PFIG to enable us to extend the existing external provider contract into March 23 – this is now a matter of urgency to action.
- A review is currently underway to ensure we continue to work closely with the external provider to meet the needs of children on the waiting list who are outside the usual referral criteria.

When performance is going to improve by and by how much

- The use of the external provider during 2021-22 has enabled us to improve our performance against achieving the **WG target from 23% waiting within target in April 2021 to 47% by end May 2022**. We need to ensure that this improvement continues with careful monitoring and support for further use of an external provider, while we work to increase internal capacity.

What are the risks to this timeline?

- Admin capacity/staff shortages, causing possible failure to upload the number of referrals required to be sent to the external provider each month.
- Failure to appointment a Programme Manager and Clinical Lead to support the service improvements/ and developments
- Failure to extend the current contract and scope out the requirements of the new tender in a timely manner
- Failure to secure additional funding required to ensure any improvements and new tenders address the capacity gaps and enables us to continue to develop the service.

What are the mitigations in place for those risks?

- We are ensuring there is increased support for the admin staff to enable timely upload of referrals to the external provider and the weekly area monitoring of referrals.
- Actively continue to develop an attraction strategy to ensure lead posts are filled to support the development plans required.
- Work is continuing to develop a model of care and implement an agreed service approach following the vanguard workshops
- Escalation to Children Services Group, Area Leadership Teams and Childrens Community Clinical Advisory Group

Quadruple Aim 2: Adult Mental Health Measures

Frequency	Measure	Target	Actual	Trend
Apr 22	Percentage of mental health (Adult) assessments undertaken within 28 days of referral*	>= 80%	54.49%	⬇
Apr 22	Percentage of therapeutic interventions (Adult) within 28 days of assessment*	>= 80%	77.83%	⬆
Apr 22	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy*	>= 80%	69.57%	⬇
May 22	Total Number of mental health delayed transfer of care (DToC) patients	Reduction	15	⬇
May 22	Total Number of mental health delayed transfer of care (DToC) bed days	Reduction	696	⬇

* Reported 1 month in arrears

Quadruple Aim 2 Adult Mental Health Delayed Transfers of Care :

What are the key issues/ drivers for why performance is where it is?

Availability of appropriate residential/nursing home placement remains the main barrier to timely discharge from our care.   Those of our patients with complex physical and mental health care needs require bespoke placements and packages of care that need to be built around the individual. The very specific nature of the placements means they are not readily or routinely available.

What actions are being taken to improve performance and by who?

Post hospital care and environment needs are discussed and managed from the point of admission to ensure needs are appropriately assessed and to mitigate the time required to co-ordinate the packages of care needed.
Routine review of discharge status and working with MDT discharge teams to facilitate timely discharge.
We are working with the DU as part of the national Expert Group for review of the DToC measure, which was stood down at the start of the Covid-19 pandemic. Discharge to Recover then Assess (D2RA) replaced DToC for physical health care but not for Mental Health. It is envisaged that the developing process for Mental Health will better reflect our positon and support the process for timely discharge.

When performance is going to improve by and by how much

We have seen improvement in recent months not only in the numbers of patients delayed but also in the number of days delayed for each patient. Due to both the complexity of our patient needs and the external factors that impact on the timely discharge of our patients, we don't anticipate a further reduction in patient numbers in year but intend to focus on ensuring we do not see any significant increase in days delayed for our individual patients.

What are the risks to this timeline?

The availability of appropriate placements and packages of care and/or the time required to build bespoke placements. Any increase in the flow through our services of mental health patients with comorbidities will also be a significant risk.

What are the mitigations in place for those risks?
Discharge planning from the point of admission is supporting a more timely discharge. Longer term mitigation includes work within our pathway development to include a focus on both physical and mental health wellbeing.

What are the key issues/ drivers for why performance is where it is?

Achievement of staffing level to establishment is the key issue in supporting compliance against all parts of the Mental Health Measure. Due to the fragility of maintaining services without full establishment of staff even a relatively small increase in referrals into service are compounding our ability to deliver in line with Key Performance targets.

What actions are being taken to improve performance and by who?

We have a dual approach to improving performance for our patients. The first is our immediate recovery plans which focus on recruitment to establishment posts, recruitment to interim additional posts to support the management of the backlog, undertaking additional sessions along with streamlining and improving our processes. These recovery plans will remain in place whilst we develop the second fundamental element to our improvements which is the development of our Tier 0/1 services. This is being developed collaboratively with colleagues across the divisions, clusters and informed by the feedback from our services users. Development of the model will strengthen the offer of our divisional expertise into a multi disciplinary team that ensures we are removing the wait to assessment for service users, ensuring they are receiving the right level of care, in the right pace at the right time.

When performance is going to improve by and by how much

We have variance in capacity and demand across our region and recovery will be dependent on those variables. Our East area is projected to be compliant with all parts of the measure by the end of Quarter 1 2022. Both the West and Central teams are focusing on the longest waiters which, whilst clinically the appropriate action, will in the short term have a negative impact on compliance with the measure. Addressing the waiting list backlog will by year end result in compliance against the measure for all areas and most importantly timely access to care for our service users.

What are the risks to this timeline?

Any significant increase in demand will impact on our ability to achieve compliance as will any delays with recruitment to the existing and new posts.

What are the mitigations in place for those risks?

We are increasing focus on recruitment with internal scrutiny of progression through Trac. We are reviewing referral demand on our services in order to reflect and adjust our response in the levels of assessment and intervention to be undertaken. We are progressing development of our Tier 0/1 model with the recruitment of project support staff in June 2022.

What are the key issues/ drivers for why performance is where it is?

Our West and Central Regions are fully compliant against the Adult Psychological Therapies Key Performance target and have maintained this achievement throughout the year. The position in the East has deteriorated due to vacancies in some key roles.

What actions are being taken to improve performance and by who?

Focus on recruitment to the vacant roles, included some changes to posts to make them more effective and attractive.

When performance is going to improve by and by how much

Recruitment to posts and addressing of the backlog is anticipated to bring us back to fully compliant levels by end of Quarter 2 2022

What are the risks to this timeline?

Any significant increase in demand or delays to recruitment will impact on our recovery.

What are the mitigations in place for those risks?

We are increasing focus on recruitment with internal scrutiny of progression through Trac. We have reviewed roles to make them more effective and attractive.

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.

Period	Measure	Target	Actual	Trend
Q4 2021/22	Percentage of complaints that have received a final reply (under Regulation 24) or an interim reply (under Regulation 26) up to and including 30 working days from the date the complaint was first received by the organisation	75%	60.00%	⬇
Q4* 21/22	Number New Never Events**	0	2	⬇
May 22	Doctor Appraisal / revalidation rate	95%	96.84%	⬆

* Number of New Never events Reported in Q4 of 2021/22.

**Trend based latest 6 historic data points (Q3 2020/21 to Q4 2021/22)

Nationally Reportable Incidents BCUHB starting January 2021-BCUHB starting 01/01/21
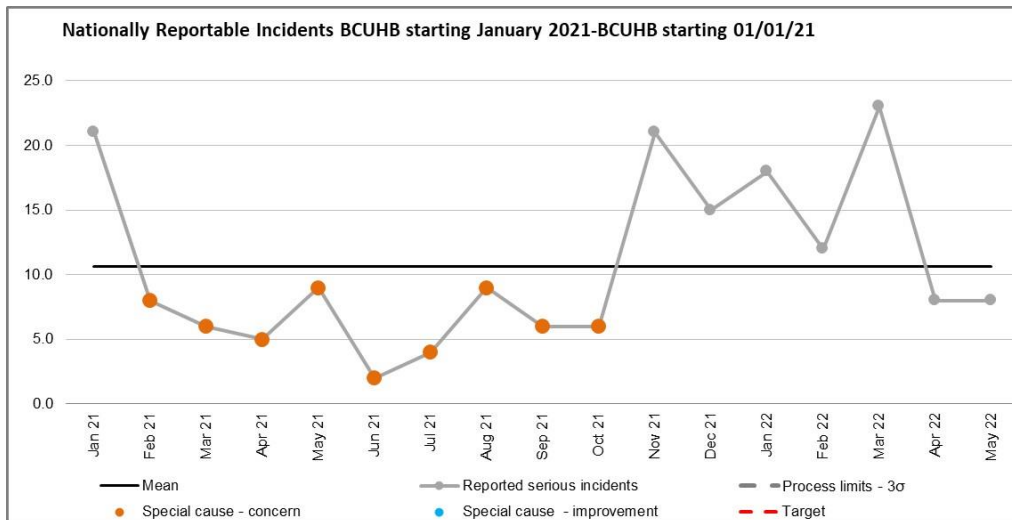
- Reporting from June 2021 reflects the changes in reporting criteria as detailed in Phase 1 of the NHS Wales National Reporting Policy, in particular the requirement to report only falls resulting in severe (i.e. permanent harm) and will only include avoidable HAPUs upon completion of the investigation.
- There has been a decrease in the number of Nationally Reportable Incidents. In April and May, 6 falls resulting in permanent harm were reported. There were also 8 incidents reported where failure to recognise and escalate a deteriorating patient has resulted in severe harm. This is an ongoing theme across our acute sites. Further detail is included in the Patient Safety Report.

Nationally Reportable Incidents closed on time BCUHB starting January 2021-BCUHB starting 01/01/21
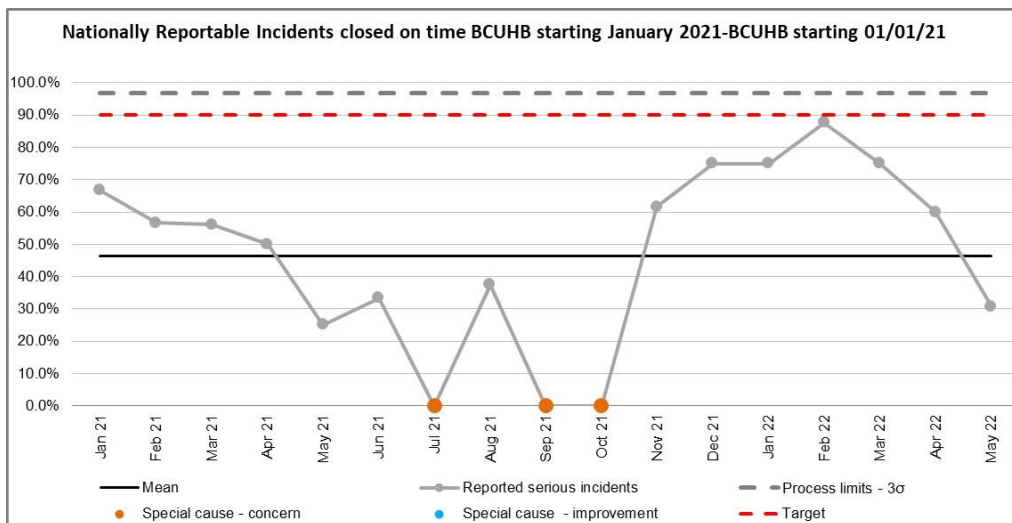
- The review of process and improved monitoring on the progress of investigations resulted in a continued improvement in performance of incidents closed on time since October 2021. However, there has been a significant decrease in the overall closure rate within the agreed timeframe: April at 60%, falling to 30.8% in May. The disappointing decrease in performance is reported to be accounted for by the impact on services from clinical pressures, high staff sickness levels and gaps within services due to current open vacancies.

No. Never Events (date of incident)

Falls with harm (moderate, major, catastrophic incidents) BCUHB starting January 2021
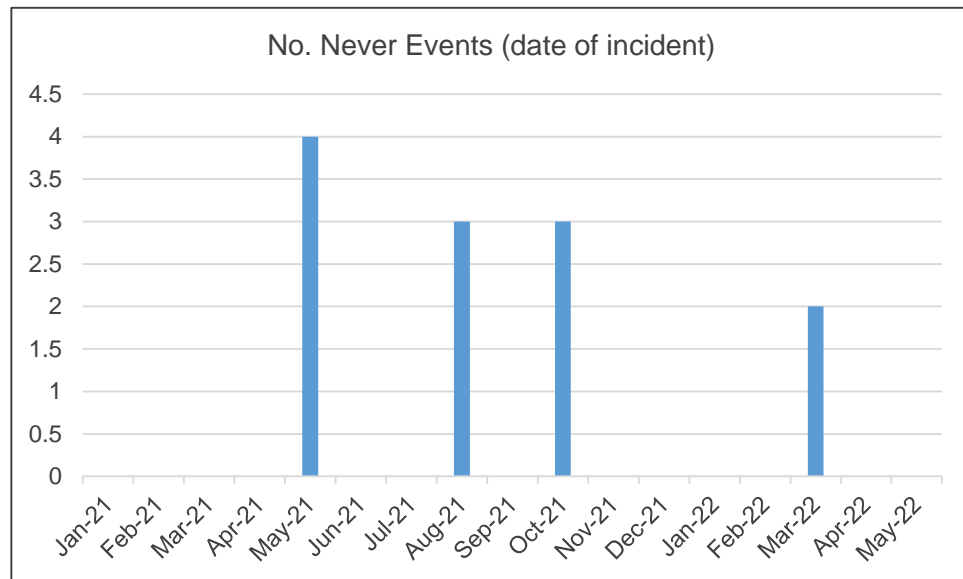
- There were no new Never Events reported during April and May. The Health Board currently have 6 open Never Events that are being investigated and are awaiting completion in order to be reviewed at the Incident Learning Panel.
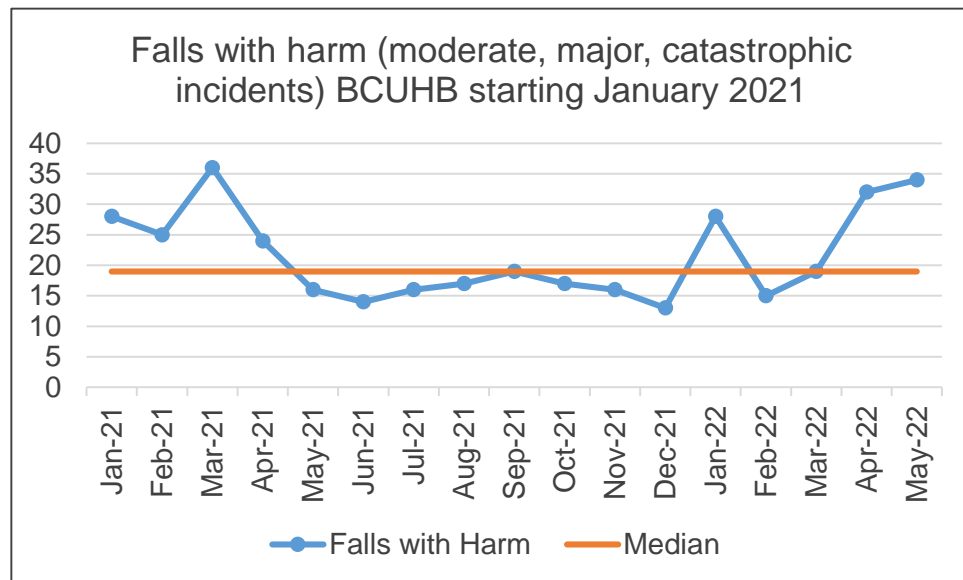
- The number of falls reported with harm (categorised as moderate, major and catastrophic within the incident reporting system) has increased in April and May (although the number of falls with severe or permanent harm have reduced in this time period).
- There are a number of interventions ongoing including the Strategic Falls Group looking at training, policy and measurement.
- Part A of Falls training module is now part of mandatory training on ESR for all staff. Part B for clinical staff was launched in March 2022.
- Since June 21, falls are only nationally reportable if death or severe harm has been caused by any action or inaction in the course of their care. In April and May, 6 falls resulting in permanent harm were reported.

Number of formal complaints received
BCUHB
starting January 2021

Number of OTS/ER complaints received
BCUHB
starting January 2021
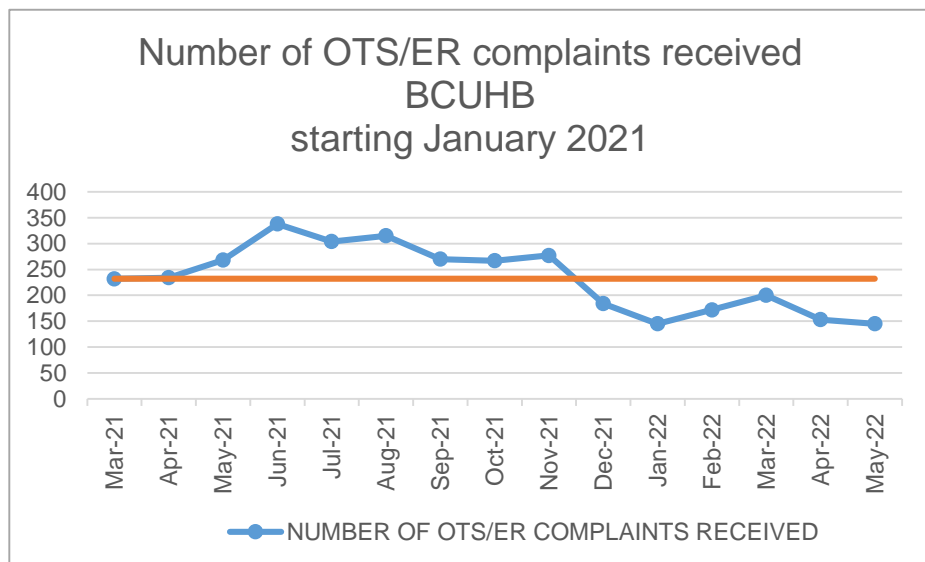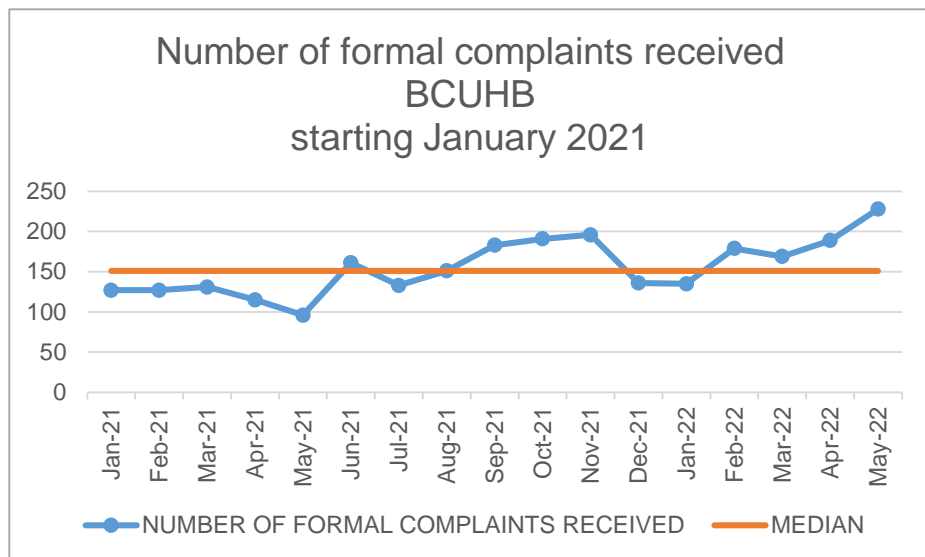
- The number of complaints managed under Putting Things Right received during April and May 2022 has shown a marked increase over previous months, being significantly above the median level; this has impacted performance.
- The majority of the complaints relate to secondary care services with Clinical Treatment/Assessment being the predominant theme. Complaint management within secondary care services has proven challenging due to capacity and staffing issues; this is being addressed by way of a Complaints Recovery Plan. However, the new complaints procedure has contributed to improved complaint responses and the quality of those responses.

- The number of Early Resolution complaints has decreased during April and May 2022 and is significantly below the median level, with the themes in relation to appointment waiting times and communication issues. The number of complaints upgraded to being managed under PTR complaints remains low. This demonstrates the proactive approach by the Complaints Team and services to resolve the complaints in a two day time frame (for those that do not allege harm).

% formal complaints acknowledged within 2 days BCUHB starting January 2021

- % ACKNOWLEDGEMENT RATE
- TARGET
- MEDIAN

% formal complaints responded to within 30 days BCUHB starting January 2021

- % RESPONSE RATE
- TARGET
- MEDIAN
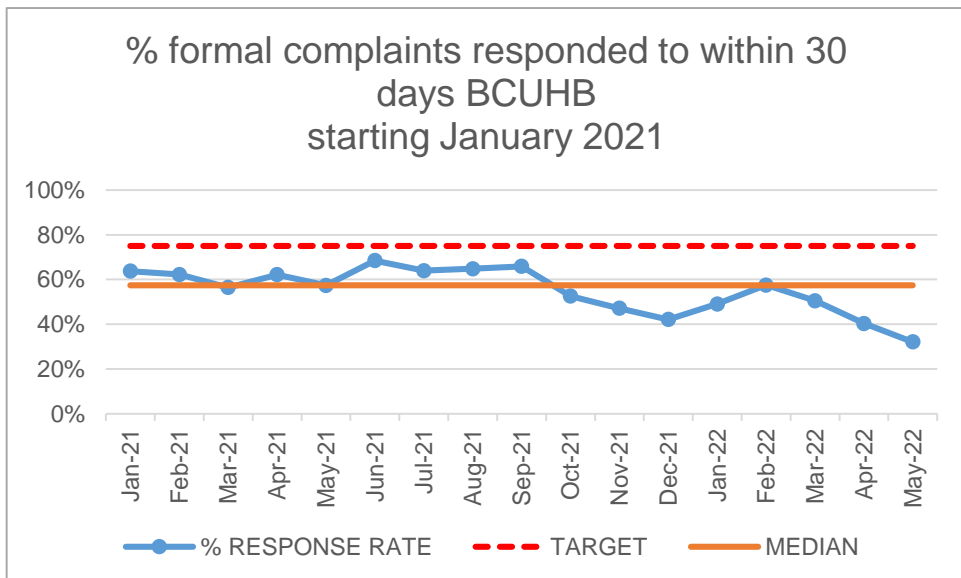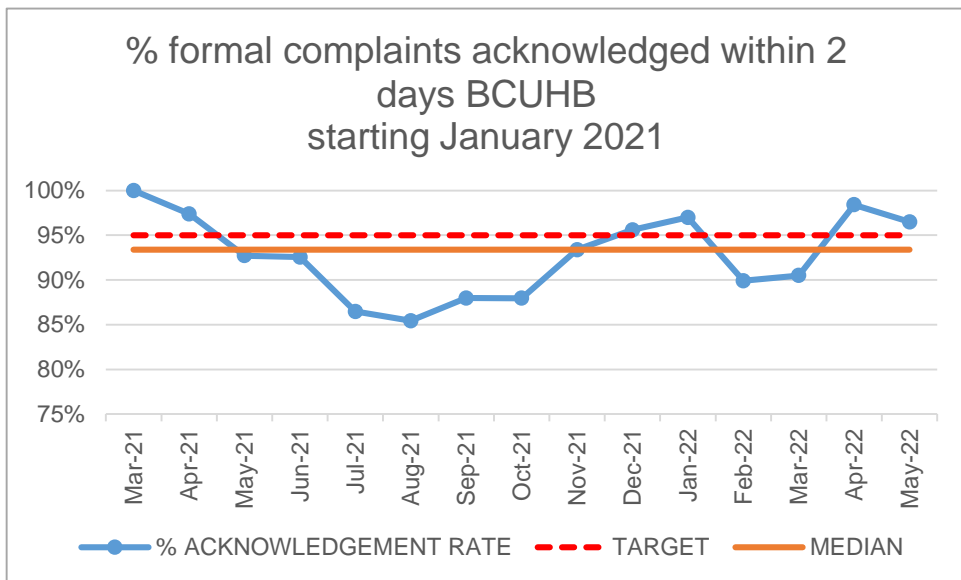
- There has been a marked improvement in performance against the acknowledgement within 2 days target in April and May, with the level now exceeding both the target level and the median level since January 2021. Following a thematic review, 60% of the complaints received were related to Secondary Care services, of which 37% were Grade 3 complaints and 36% were Grade 2 complaints. The majority of complaints related to Clinical Treatment/Assessment (38%), with Lack of treatment (9%), Delay in receiving treatment (7%) and Incorrect/insufficient treatment (6%) being the three main sub-subjects.

- There was a marked improvement in performance against the responded within 30 days target in January and February, however there has been sustained decrease in performance against this target in March, April and May with the level falling back well below the median level for the previous twelve months. The impact of Covid-19 has been significant on the staffing levels within services, which has in turn impacted responses within the timescale. The Complaints Recovery Plan is in place and the Complaints Team are working with services individually to support improvement.

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.
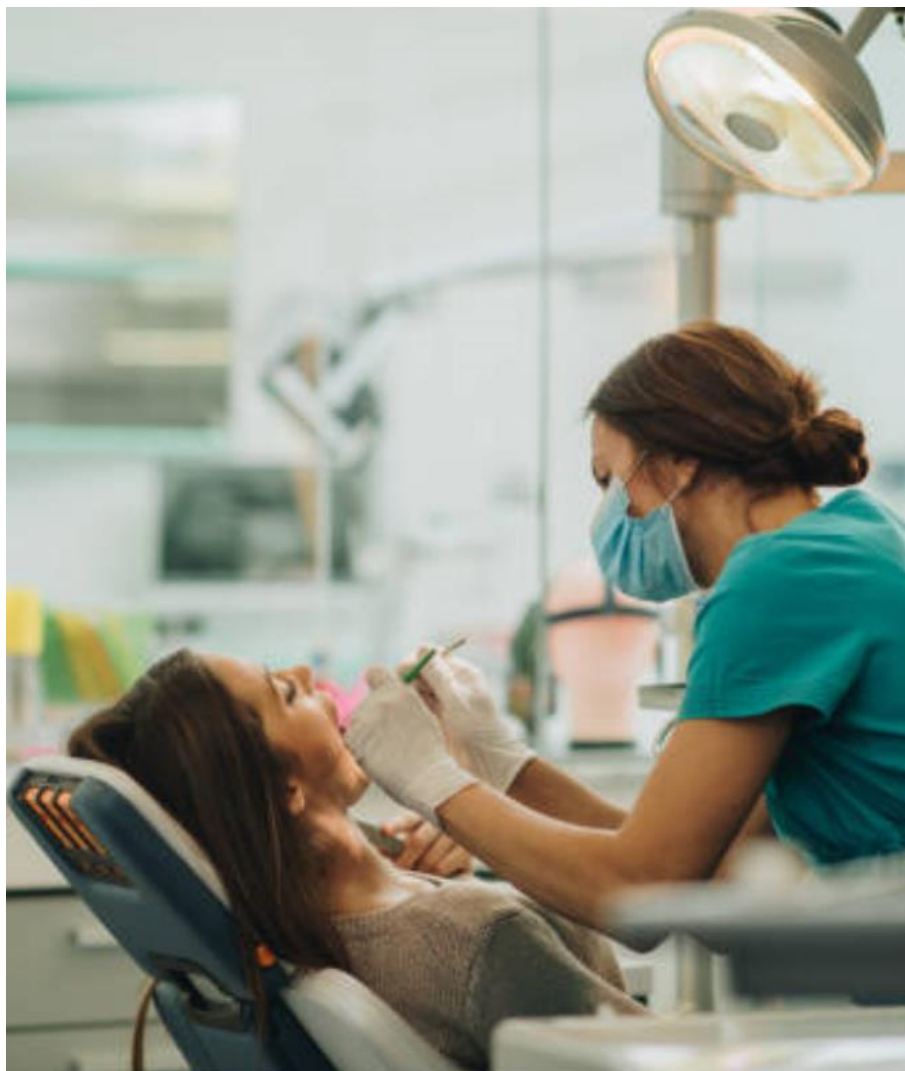
Period	Measure	Target	Actual	Trend
Mar 22	Crude hospital mortality rate (74 years of age or less)*	Reduction	0.98%	→
Mar 22	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening**	Improve	40.00%	↓
Mar 22	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening**	Improve	4.50%	↓
Apr 22	Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours *	Improve	72.40%	↑
Mar 22	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Improve	92.90%	↓

* Rolling 12 months reported 1 month in arrears
**Latest data, in arrears

What are the key issues/ drivers for why performance is where it is?

The mortality governance structure continues to develop – with an established fortnightly learning from death panel. This is allowing the identification of themes, either by disease or area- and has already developed and co-opted some specific areas. These are decisions of DNACPR, and issues around palliative care. The structure needs to be embedded in anticipation of the structural changes of afoot around Health Economies- and connect sites and area – so that where issues are identified whether by in primary care, the ambulance, the ED , the ward or the community hospital- a holistic approach can be adopted to learn and improve care.

What actions are being taken to improve performance and by who?

Networks. For mortality reviews to really work well, we need to establish a web of interconnected M&M's and be able to connect relevant learning to the right departments. This is something that is evolving.

Momentum- a lot has happened in mortality establishing governance structures in the last six months- and this needs continued fortification and support – as about 90 cases a month need reviewing and the necessary process to address concerns from important stake holders such as the ME service and families.

Communication. The comms strategy around learning has not yet evolved. There is a hope that rather than use dated newsletters more innovative and interesting ideas could be used- such as podcasts. Work is ongoing for this strategy

When performance is going to improve by and by how much

There is a secondment for a full time band 6 to join the team. This will help with performance in terms of the sieve and sort process and make sure issues are identified promptly and in a timely fashion so can be addressed.

What are the risks to this timeline?
There are risks- around developing and supporting the team- which is still new and emerging. There are risks around the interconnectivity with other aspects of the 'harms' agenda such as inquests, Datix , SIRS etc.

What are the mitigations in place for those risks?

What are the key issues/ drivers for why performance is where it is?

Sepsis is a huge area- and has ramifications across many different specialties and areas in North Wales. Traditionally in BCUHB – death around sepsis has not been captured – and looked at in isolation, whether be systems based i.e. Respiratory, ITU, urological, post op etc. The coding for sepsis does not allow interrogation on this system basis, but identifies on organisms- such as pneumococcal or gram negative- so interpretation of CHKS results has to be taken with some caution. Therefore it is imperative that there is cross triangulation with other areas such as the independent ME service and inquests where sepsis is cited. Only by looking at sepsis from different aspects will issues emerge that need addressing. With the above caveats- review 2022 data around streptococcal sepsis reveals a mortality rate is higher in BCUHB compared to peer of Welsh Hospitals – in the first three months of 2022 mortality rate is –BCUHB 22%, 30%, and 29%- compared to peer of 21%, 30% and 21%-this puts us in the bottom three in terms of performance of the nine HB's in Wales. Looking at the ME referrals there have been 71 referrals from Jan –May 2022 to BCUHB due to concerns of sepsis.44% YGC, 36 %YG, 14% WXM. This ranges between 15-20 cases per month .

What actions are being taken to improve performance and by who?

With regards to the above there is a huge amount that still needs to be done to build the governance and the informatics around sepsis to connect bedside to boardroom and this can come through many avenues. The learning from mortality panel- reviews cases and where there are specific issues around sepsis this is flagged up to the site and local Health Economy. Of note, this has not yet emerged as a theme – but reviews are ongoing. We are also keen to have the data for BCUHB around puerperal and neonatal sepsis being collected and focused centrally. Whilst there may actions taken in various departments to address issues to improve sepsis- at present there appears to be no specific capture of these at a corporate level- either by site, or by discipline and this is certainly a theme across BCUHB where are yet to develop the intelligence and networking around many aspects of care

When performance is going to improve by and by how much

It is envisaged that by fortnightly learning form mortality panels reviewing mortality- where trends emerge, and cases are presented – specific issues can be captured – and an action plan produced. We are also setting up a joint clinical coding board, for which the AMD Mortality will Chair- so we make sure that we can harness the write questions from CHKS

Period	Measure	Target	Actual	Trend
Q3 2021/22	Percentage of Health and Care Research Wales non-commercial portfolio studies recruiting to target	100%	55.00%	⬇
Q3 2021/22	Percentage of Health and Care Research Wales portfolio commercially sponsored studies recruiting to target	100%	11%	⬇
Q3 2021/22	All new medicines recommended by AWMSG & NICE, must be made available where clinically appropriate, no later than 2 months from appraisal recommendation.	100%	99.40%	⬆
Q4 2021/22	Total antibacterial items per 1,000 STAR-PUs	< 211.3	250.08	⬇
Q2 2021/22	Percentage of secondary care antibiotic usage within the WHO Access category	> 55%	61.60%	⬆

Period	Measure	Target	Actual	Trend
Q4 2021/22	Number of patients age 65 years or over prescribed an antipsychotic	Reduction	2,420	➡
Q4 2021/22	Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age	Improve per Quarter	0.15%	⬆
Q4 2021/22	Opioid average daily quantities per 1,000 patients	4 Quarter reduction	4,644.9	⬆
Q3 2021/22	Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product including biosimilar (for a selected basket)	Improve per Quarter	83.80%	⬆

Additional Information

Percentage Mental Health Assessments (CAMHS) within 28 days of Referral (April 2022)

Legend: 2020/21, 2022/22, 2022/23, Target
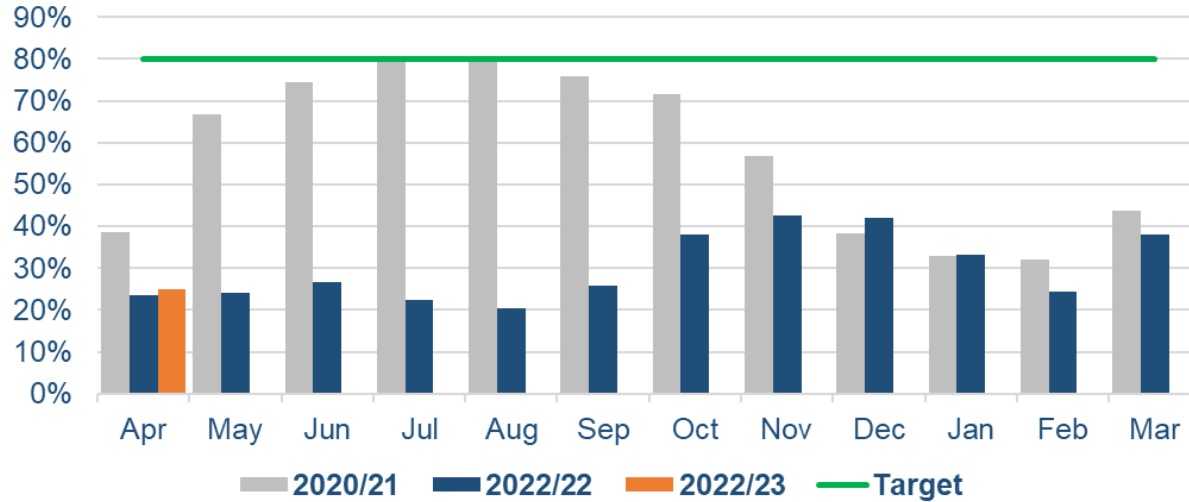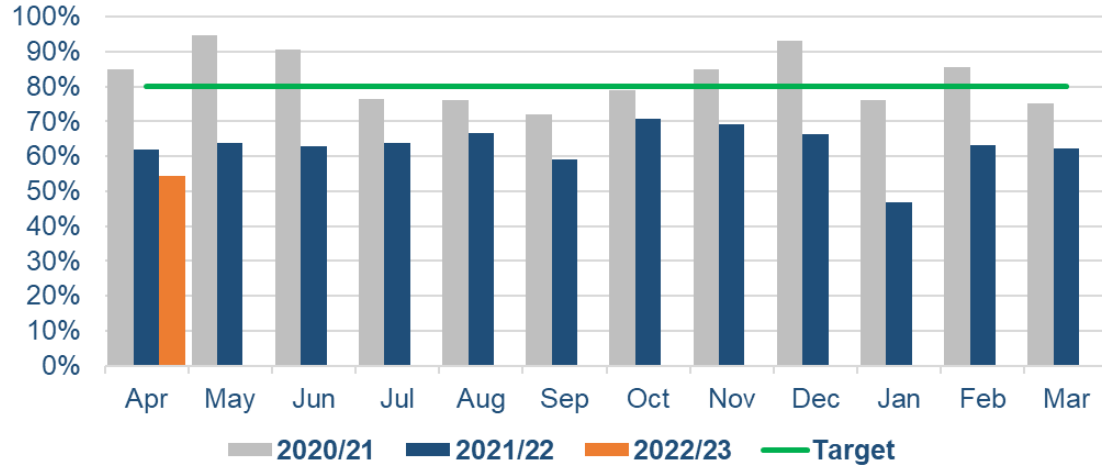
Percentage Mental Health Theraputic Interventions (CAMHS) within 28 days of Assessment (April 2022)

Legend: 2020/21, 2021/22, 2022/23, Target

Data is reported 1 month in arrears
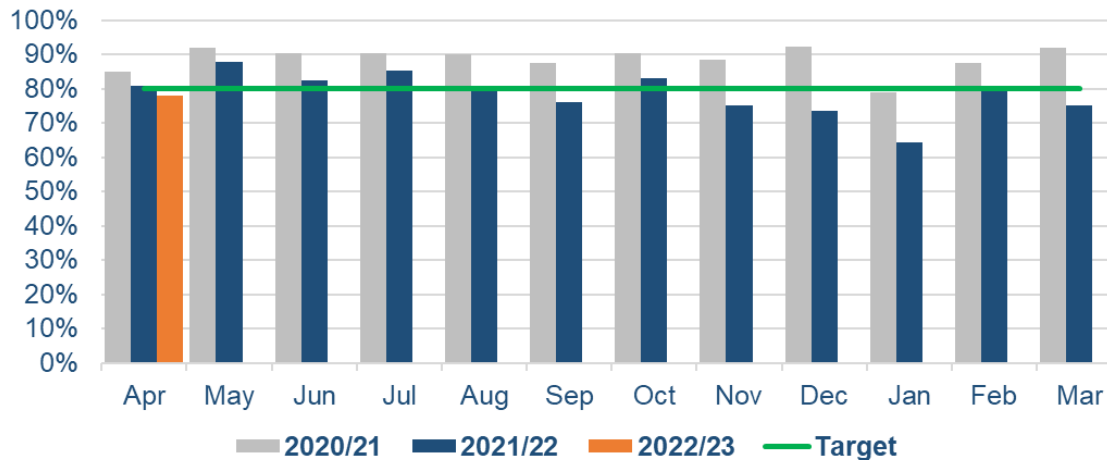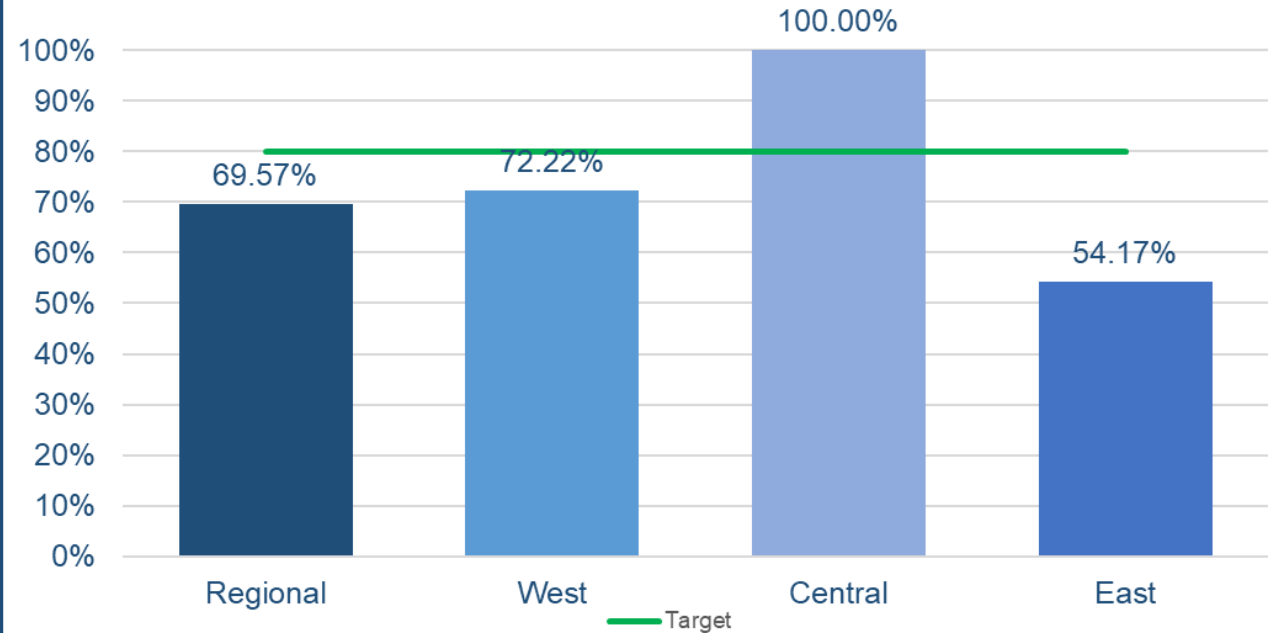
Quadruple Aim 2: MH Delayed Transfers of Care
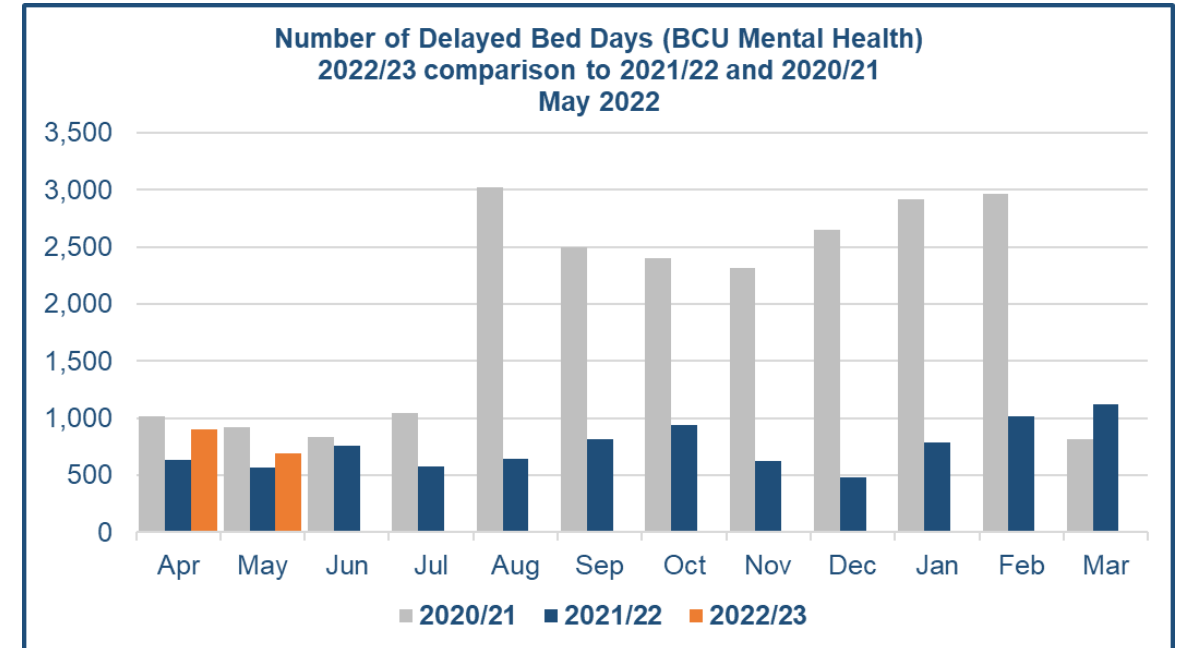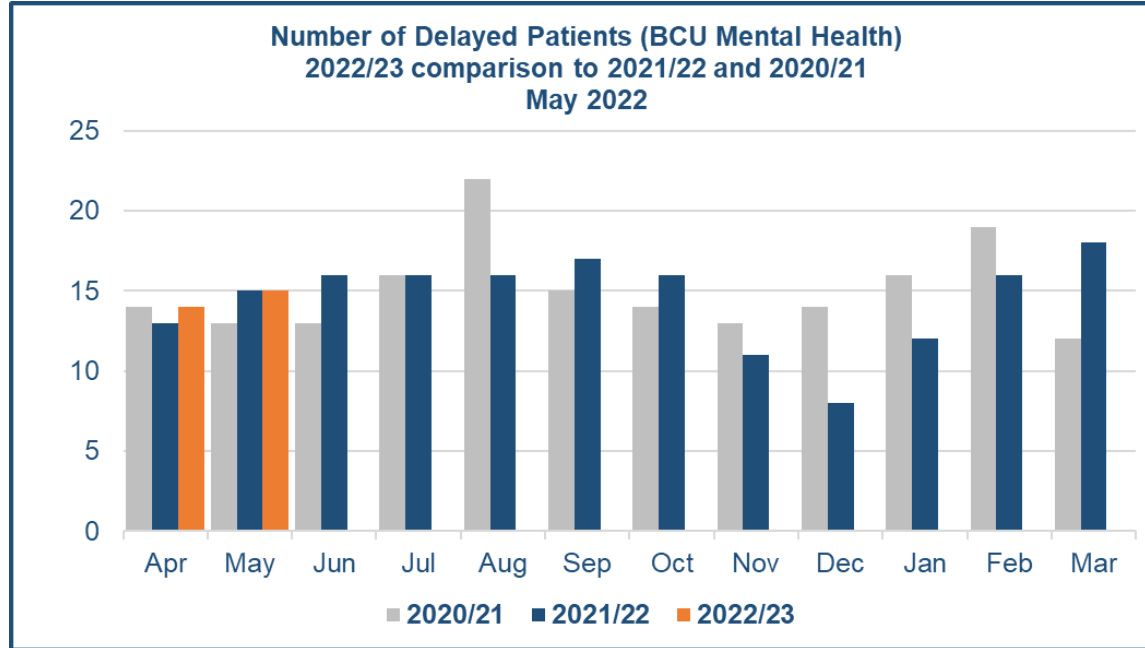
Emergency Departments - 1 Hour Compliance Sepsis Six Bundles to 31st March 2022

Legend: Forms Completed, Bundle Compliant, S6 Compliance

* Inpatients - 1 Hour Compliance Sepsis Six Bundles to 31st March 2022

Legend: Forms Completed, Bundle Compliant, S6 Compliance
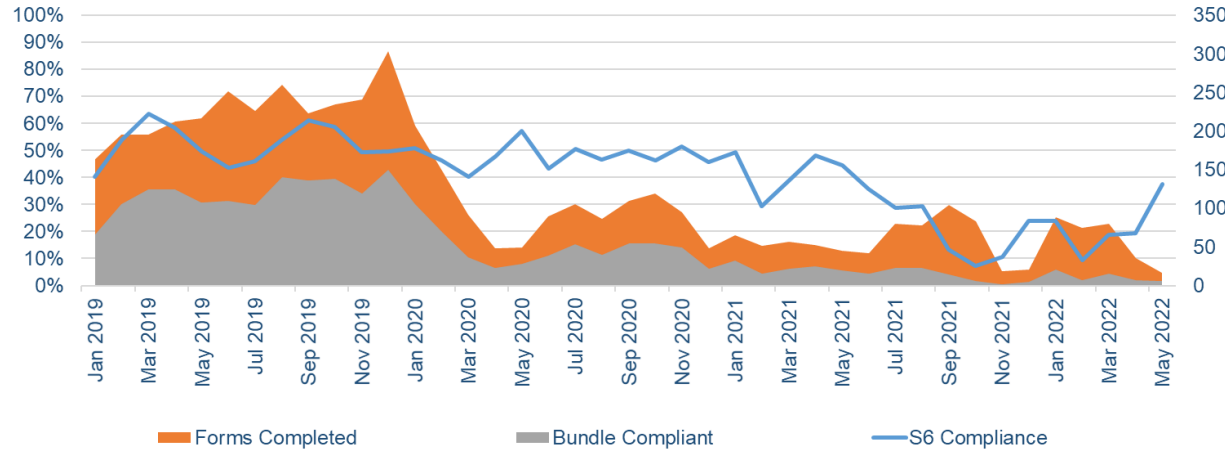
Important Note:
The blue line in these two graphs represent the % compliance with Sepsis Six Bundle provision within 1 Hour of suspicion of a sepsis infection.

The orange 'area' represents the total number of Sepsis Six Forms that were completed.

The Grey 'area' represents the total number of forms completed where they were compliant with the Sepsis Six Bundle measure.

The graphs show a significant reduction in the numbers of forms being completed in both Emergency Department and Inpatient settings across all 3 sites. This reduction in recording of data occurred at the same time as the beginning of the COVID-19 Pandemic and has not yet recovered. Although there are signs of recovery – per the updated data in Emergency Departments.

*Inpatients data is being checked/clarified for April and May. Currently doesn't match historic.

Impact of COVID-19 Pandemic on Unscheduled Care

Unscheduled Care Performance by Site
13th June - 19th June 2022

Measure	West	Centre	East	BCU
ED&MIU Number of Attendances	1443	1660	1270	4373
ED&MIU 4 Hour Performance	62.86%	60.60%	43.46%	56.37%
ED Number of Attendances	1046	1164	1070	3280
ED 4 Hour Performance	49.04%	44.42%	36.92%	43.45%
ED 12 Hour Breaches	197	297	243	737
1 Hour Ambulance Handover Breaches	136	182	108	426
Red 8 Minute Ambulances	62	55	64	181
Red 8 Minute Performance	33.87%	58.18%	45.31%	45.30%

Red 8 Minute Ambulance data is unvalidated and not for sharing outside this report
Sources: Red 8 Minute - WAST Health Board Area Report; ED and Handover - IRIS, accessed 20/06/2022

Impact of COVID-19 Pandemic on Referral Rates
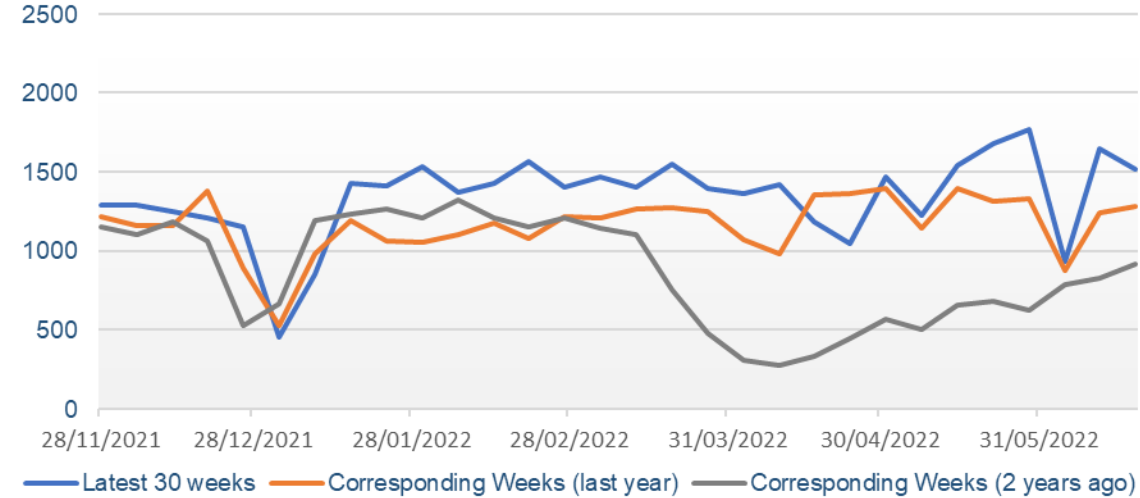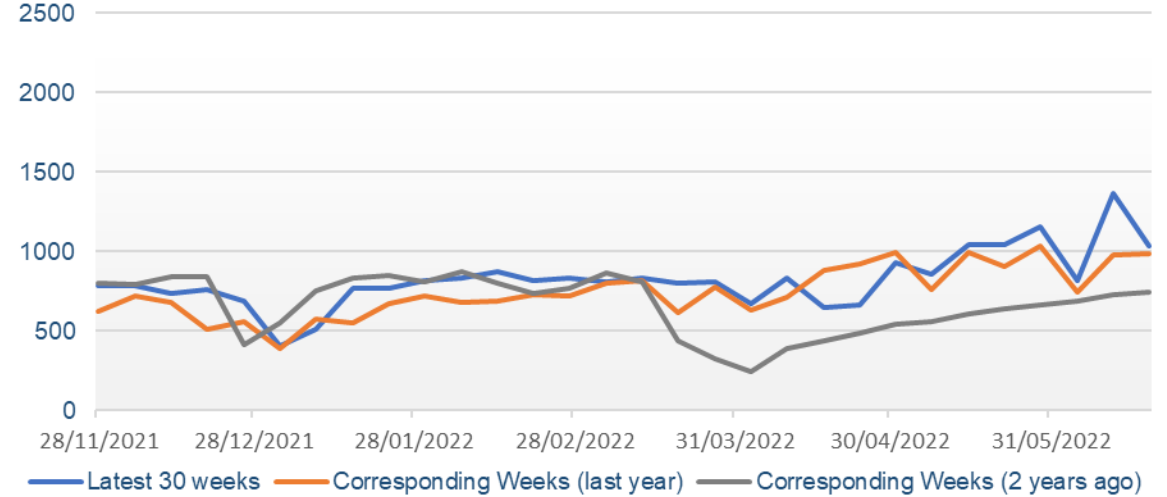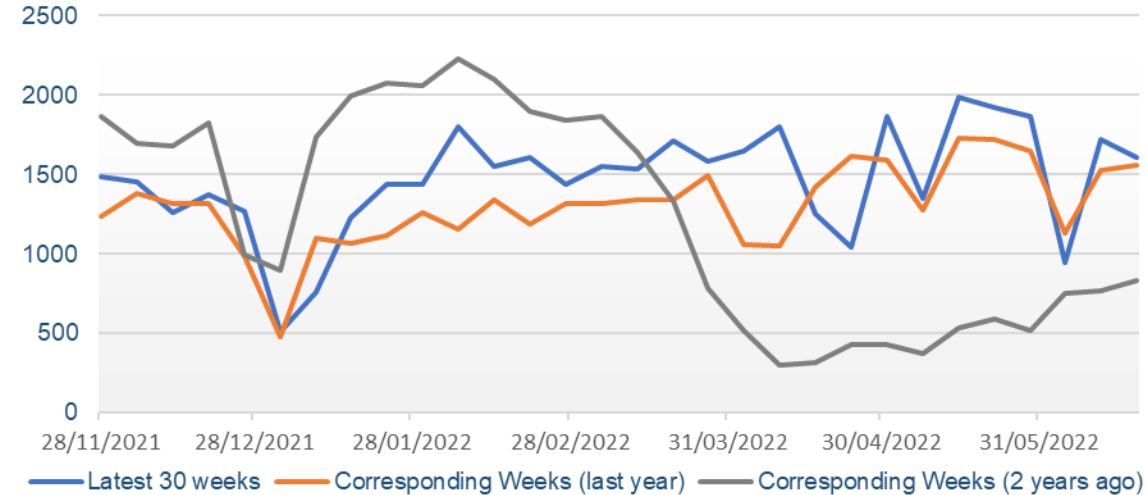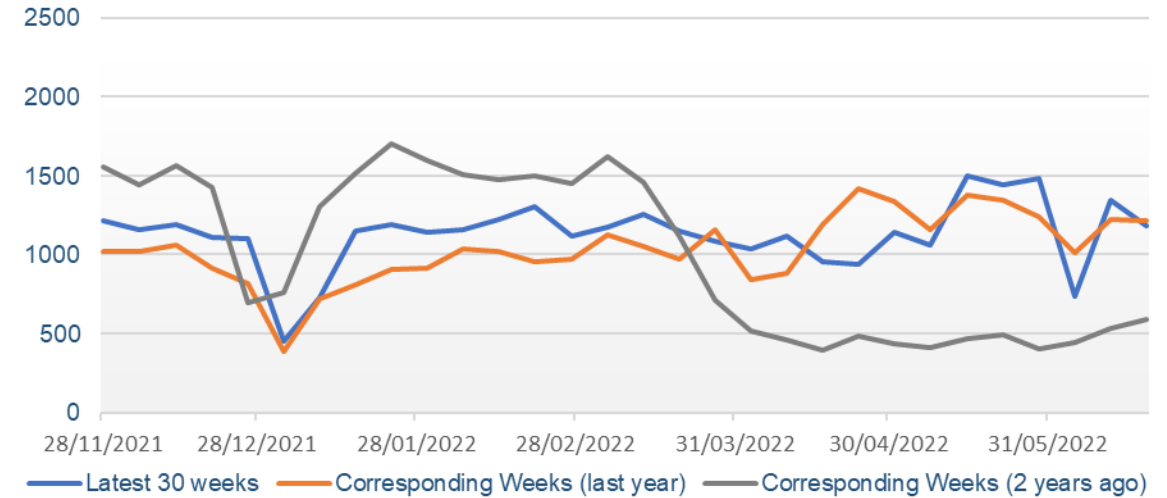
Impact of COVID-19 Pandemic on Planned Activity

RTT High Level Report - Core Outpatient Activity (new, RTT, face to face attended appointments)
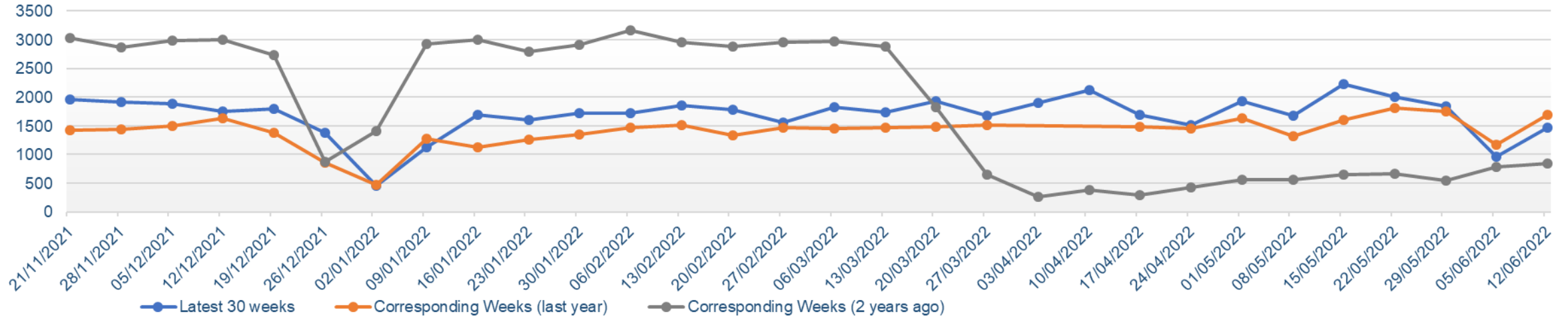
Theatre Procedures (Inpatient and Daycase): Completed Elective Cases in Planned Elective Lists by Week
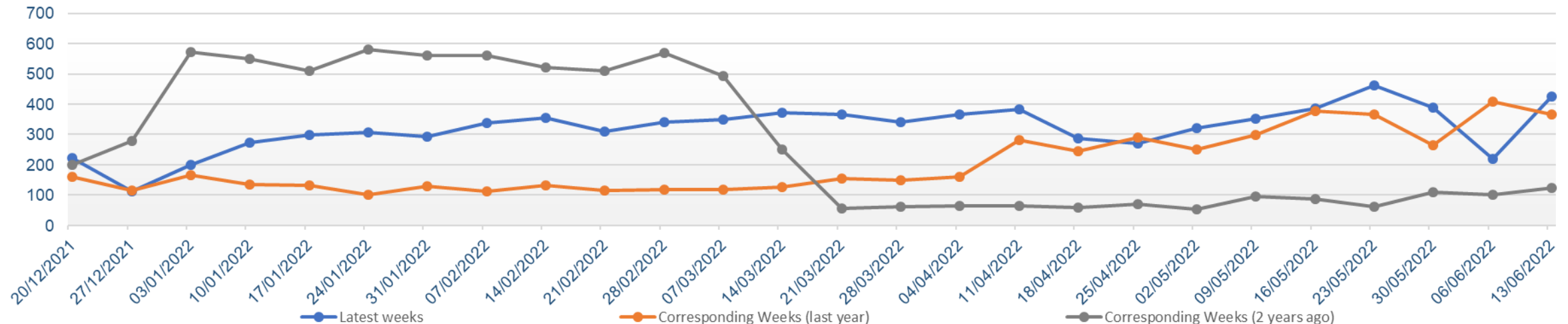
Further Information

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

- tolerances for red, amber and green

Further information on our performance can be found online at:

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

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

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

Report title:	Patient Safety Report: April 2022 – May 2022		
Report to:	QSE Committee		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	3.4 QS22.214
Executive Summary:	This report provides the Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.		
Recommendations:	The committee is asked to receive this report.		
Executive Lead:	Gaynor Thomason, Interim Executive Director of Nursing and Midwifery		
Report Author:	Matthew Joyes, Associate Director of Quality Dr Kath Clarke, Head of Patient Safety Sarah Musgrave, Patient Safety Lead Manager		

Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☒ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

There is confidence in the data provided in the report however, the strength of learning and improvement remains an areas of concern and is a key focus of work.

Link to Strategic Objective(s):	Quality
Regulatory and legal implications	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	BAF21-10 - Listening and Learning
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	N/A
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	BAF21-10 - Listening and Learning
Reason for submission of report to confidential board (where relevant)	N/A

Next Steps: N/A

List of Appendices: Patient Safety Report (this report now includes HIW regulatory activity)

Patient Safety Report
to the QSE Committee

April 2022 - May 2022

INTRODUCTION

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

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

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

Use of data

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 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

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

Definitions

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

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

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

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

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

The Delivery Unit lifted any reporting restrictions that were put in place because of Covid-19 as of the 14 of June 2021.

Further details around changes to National Incident Reporting in NHS Wales can be found on the Delivery Unit website Patient Safety Incidents - Delivery Unit (nhs.wales).

Never Events are defined as patient safety incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have

happened as a result of a specific incident for that incident to be categorised as a Never Event. Information on Never Events are detailed in a separate section further in the report

There is one appendix to this report:

- Appendix 1 – Copy of completed HIW inspection reports

NATIONALLY REPORTABLE INCIDENTS (NRI) – PERFORMANCE

During April and May 2022, 20 nationally reportable incidents were reported, down from 42 in February and March 2022.
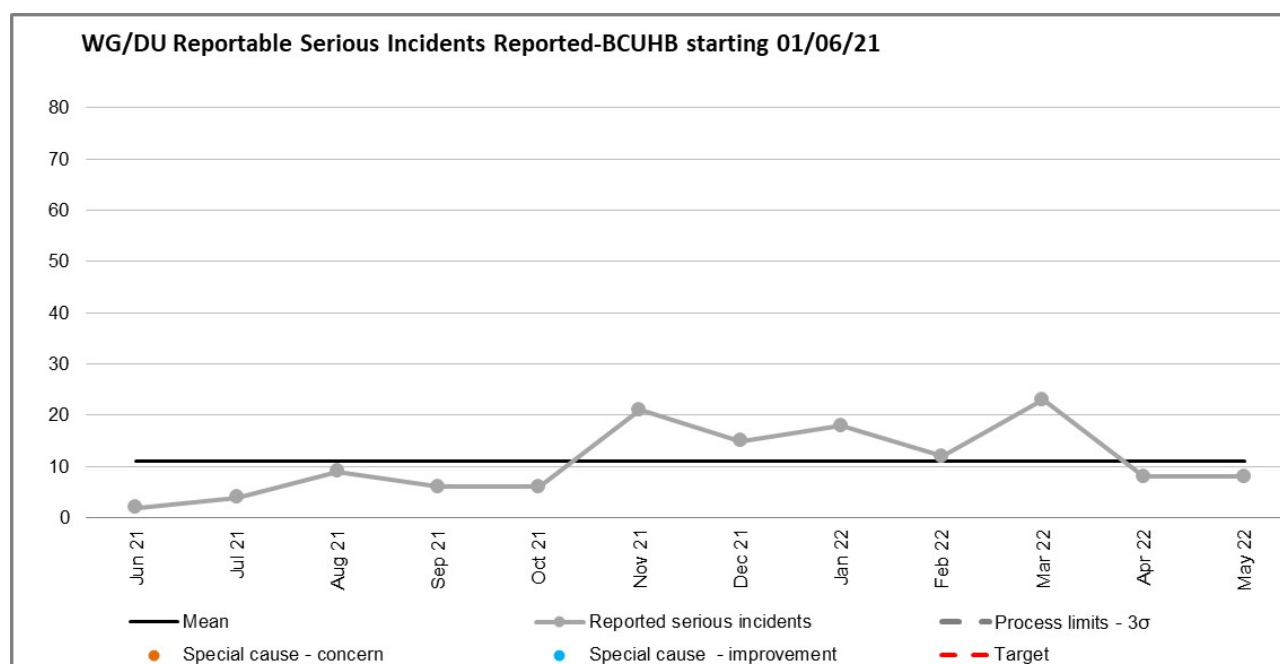
The table below shows the Health Board position in terms of reportable incidents per 100,000 population in relation to the All-Wales position per 100,000 population.

Time period	BCUHB incidents/100,000 population	All wales incidents/100,000 population
Jun/July 2021	1.0	1.8
Aug/Sept 2021	1.8	2.3
Oct/Nov 2021	3.8	3.0
Dec /Jan 2022	4.3	3.2
Feb/March 2022	6.2	3.8
April /May 2022	2.9	2.9
AVERAGE	**3.3**	**2.8**

Given the small numbers involved, and the particular reporting requirements for certain incidents which can fluctuate, the average should be considered a more useful comparison than an individual two-month period.

In line with the All Wales position there was a reduction of the number of incidents reported per 100,000 population. The numbers reported across the Health Board have fallen significantly. Last period, the Health Board reported a particularly high number of falls, and numbers in this period have returned to a more usual level.

In addition to the above mentioned nationally reportable incidents, there were eight Early Warning Notifications (EWN) reported, two of which were Procedural Response to the Unexpected Death in Childhood (PRUDiC) related. These notifications are not investigations but rather alerts of potential stakeholder interest. The other notifications relate to incidents that may attract media attention.

At the time of writing, the total number of national reportable incidents open is 69 of which 32 are overdue. The total number of open incidents has increased from 68 from the previous time period; the number that are overdue has significantly increased from 16.

Overall closure rate within timeframe was 60% in April, falling to 30.8% in May. This is disappointing considering the improved position over previous months. The impact on services from clinical pressures, staff sickness, vacancies, and staff re-deployment continued to impact on the ability of services to respond in a timelier manner to incident investigations. In addition, staffing issues within the Patient Safety Team and the introduction of the new RLDatix Cymru system in April 2022 has meant a reduction in efficiency with regards to management of the process.

The Patient Safety Team are committed to returning to performance levels seen in the previous period and is working closely with services to resolve issues that have contributed to this less favourable position.

In the immediate term, recognising the delays to full investigations, the Patient Safety Team are placing particular focus on ensuring Make it Safe Rapid Reviews are completed so that early learning to improve safety is identified and implemented.

% of DU Reportable Incidents Completed within timescale (90%)-BCUHB starting 01/06/21

Legend: Mean — Reported serious incidents — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target
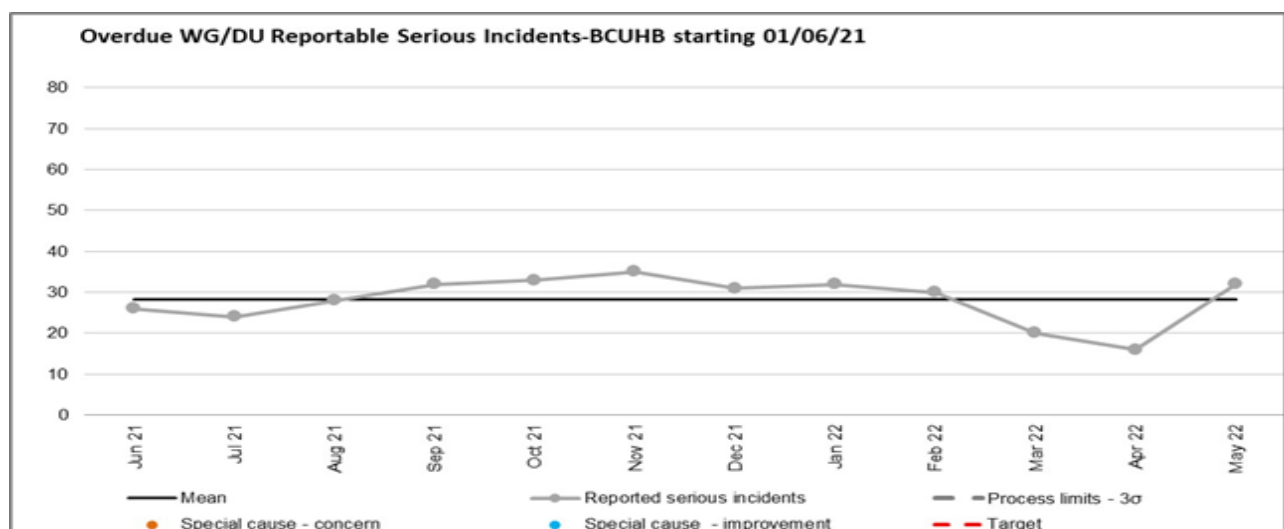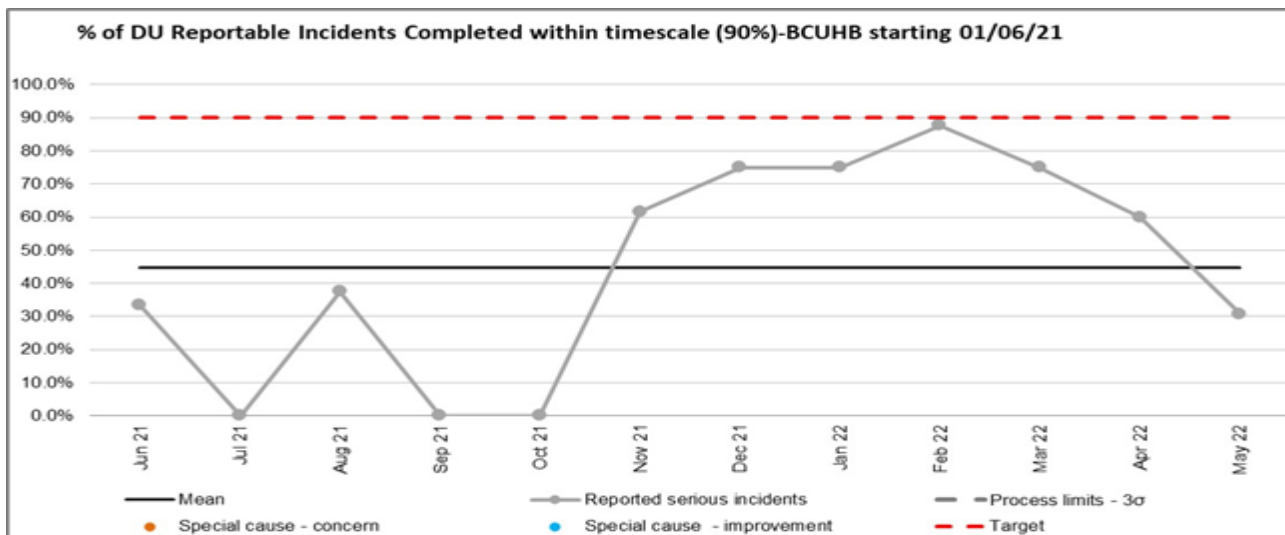
NATIONALLY REPORTED INCIDENTS (NRI) – LEARNING

There were 20 NRIs, for the two-month time period covered in this report. The NRIs recorded during this period can be broken down as follows

- Fall with severe harm (n=6)
- Grade 3 or above healthcare associated pressure ulcer develops (n=3)
- Delay or failure to monitor patient (n=3)
- Delay in diagnosis (n=3)
- Failure/delay to act on adverse symptoms (n=2)
- Unexpected death of patient not known to mental health services (n=2)
- Ambulance delays resulting in harm/death to patient (n=1)

All NRIs are subject to a Make it Safe Rapid Review, potentially a Rapid Learning Panel and a proportionate investigation. The learning and actions from each are recorded on the Datix safety management system.

Rapid Learning Panels (RLP) take place between the senior service team and clinical executives as soon as practicable following a Never Event and/or when an adverse incident where significant harm or death of a patient has occurred. The role of these meetings is to review immediate learning and actions being taken (including any cross-Health Board immediate learning), identify key risks and provide support where required. These compliment the Make it Safe (MIS) Rapid Review completed within 72 hours and the investigation completed within a specific proportionate timeframe (30, 60 or 90 working days). During April and May 2022, 12 RLP meetings took place into the most serious incidents.

The Incident Learning Panel (ILP) was introduced as part of the new Incident Management Process in April 2021. The role of the panel is to moderate and ensure that we are constantly improving the quality of investigations and reports. All investigations into serious incidents that have occurred since April 2021 have been reviewed at the ILP. There has been an initial focus on the quality of reports by the panel and services have taken on feedback provided with a subsequent marked improvement noted. During the months of April and May 2022, 58 investigation reports were presented to the ILP. This included those investigations

commissioned that do not meet the national reporting threshold. 21 reports were approved by the panel, 37 were deferred and needed further work for reasons such as the quality of the report writing or weak action plans.

In total there are 196 investigations in progress that have been commissioned by the Patient Safety Team. In total, 60% of these are over overdue. West Acute hold the largest proportion of overdue incidents, followed by Central Acute. Overdue reports are highlighted on the Weekly Quality Bulletin in order that these figures are visible to management teams. In addition, to ensure that learning is captured at the earliest stage possible, all incidents graded moderate and above are reviewed daily; and where a Make its Safe Plus review is commissioned these are reviewed at corporate level to ensure learning is captured and appropriate to promote patient safety.

The sharing of learning from incidents (beyond the immediate service) is achieved through clinical governance/quality meetings and networks, and through safety alerts where appropriate.

The system sharing and embedding of learning remains a risk for the organisation (and is contained on the Board Assurance Framework). Plans are in place to strengthen the extracting, sharing and embedding of learning to include:

- Learning on a page to replace the "lessons learned "template re-named Insight
- Monthly ILP Bulletin serving as a compendium of all the Insight reports
- A central Patient Safety Learning Library as part of the new Intranet site
- Mandated Learning Events (using the Oxford Model Event concept) following each completed investigation
- Updating the Safety Alerts Policy and process

Themes identified from Nationally Reported Incidents

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities (recognising full investigations are underway). At this time, the following are the identified themes:

- Recognition and escalation of deteriorating patient
- Falls
- Healthcare acquired pressure ulcers (HAPU)
- Surgical safety

These four theme areas are underpinned by a recurring issues of record keeping, that whilst not directly causal to an incident occurring, is contributory to the circumstances that create unsafe conditions.

These five areas form the priority projects to be taken forward as part of the Patient Safety Programme which is detailed below. The charts below show the spread of where the incidents occurred per division.

The following section provides a summary of some of the themes and the actions underway.

Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms and delay in diagnosis (n=8)

There have been eight incidents that were nationally reported during this period whereby recognition, escalation and treatment of a deteriorating patient has been delayed and subsequently resulted in severe harm or death. Six of the incidents occurred in Ysbyty Glan Clwyd and two in Wrexham Maelor.

Over the last year, the following related incidents were reported as NRIs:
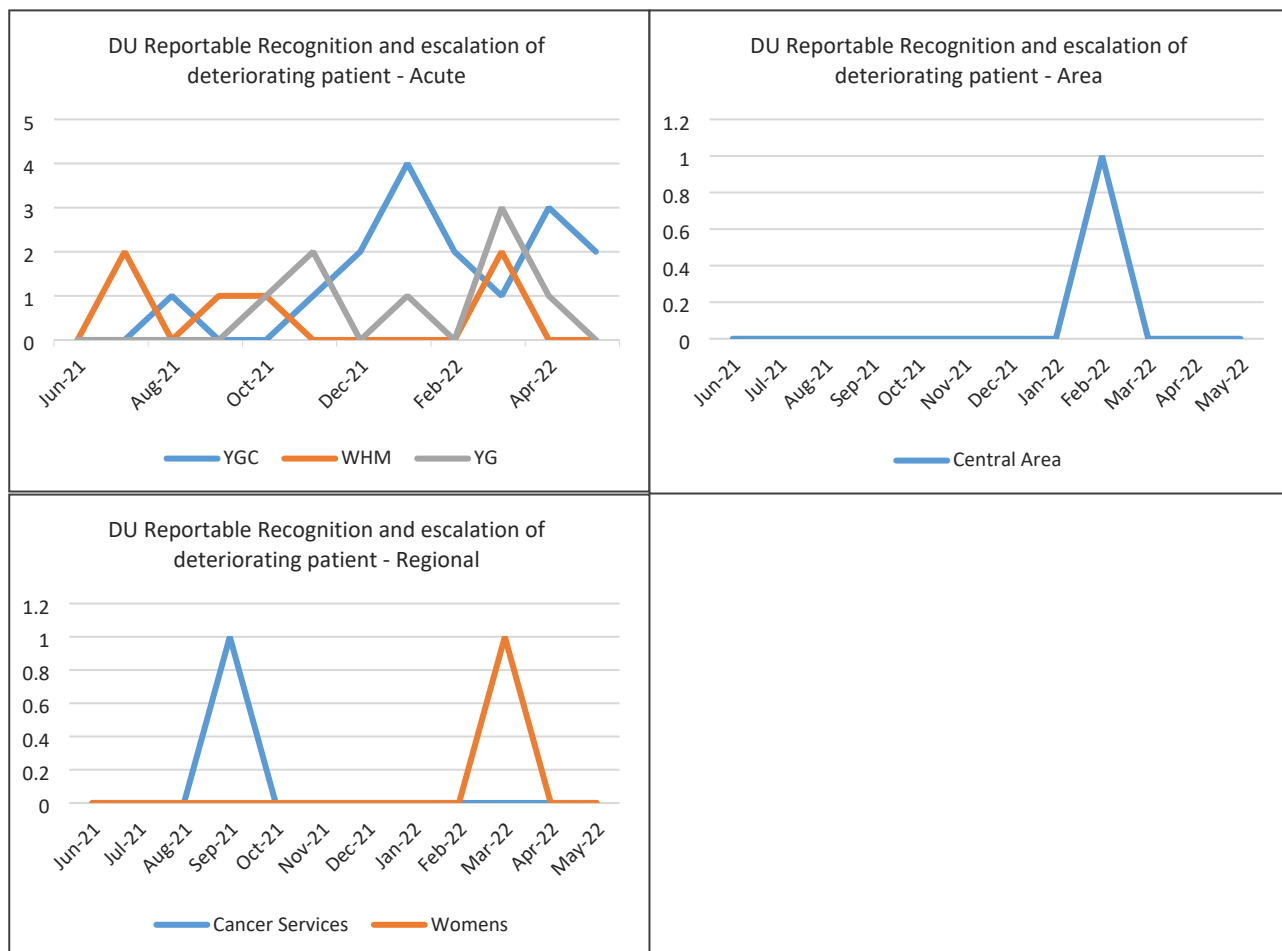
In respect of improvement, work, this will be further refined as part of the new Patient Safety Programme. Work already underway includes an audit of medical emergency team (MET) calls, being led by one of the acute site Hospital Medical Directors. In respect of immediate actions from the Rapid Learning Panels and Make it Safe Rapid Reviews:

- A MET call report has been introduced to make clear reporting easier and faster for the MET teams and not introduce difficult logistic steps. The form can be used by anyone to flag a case for audit if a particular case requires review. The data is collected on the BCU SharePoint site and is secure.
- The data is being used to show where MET calls happen, when they happen and to some degree why they happen. Most MET calls are out of hours, in patients without definitive plans and on frail patients.
- Cases will be selected randomly on a monthly basis to do more in depth reviews on what lead to the MET call and if it could have been prevented.

- A ward based "care actions on deterioration" document is being introduced designed to help clinical teams to delineate what actions might or might not be appropriate for their patients. It is only for patients who have DNACPRs but are still for active treatment. When complete it will be filed at the front of the notes with the DNACPR. This will be completed by the end of July 2022.

In addition, the Health Board has re-formed an improvement group to look at one aspect of this area. The Sepsis Trigger, Escalation and Antibiotic Stewardship Review (STEAR) Group met for the second time in May 2022 where they reviewed and further discussed the following:

- Recommendations on how the Health Board look at sepsis triggers
- Who is performing the assessments
- How we currently escalate
- How to provide good first rate care for sepsis across the Health Board
- How to provide education to meet the goals
- Compare outcomes nationwide.

These discussions are forming an improvement plan which will be monitored by the group.

A make it safe review and rapid learning panel was undertaken when a patient was not reviewed by a consultant for a period of time resulting in deterioration of condition. In addition, nursing staff failed to site an intravenous cannula due to the patient being frail and having difficult vascular access. This resulted in a delay to correct the electrolytes leading to cardiac arrest. Immediate actions:

- A "blind" audit of case-notes to ascertain timing of last Consultant led senior review for inpatients under the care of urology together with details of the medical plan was undertaken to identify gaps in provision which required targeted intervention.
- The development of a "difficult vascular access" team with dedicated staff to support staff when vascular access required. Currently being recruited to.

Falls (n=6)

Within the reporting period there were a total of 6 patient falls that resulted in severe/permanent harm and therefore met the criteria for national reporting. This is broken down as follows:

East Acute (1), West Acute (4), West Area (1)

This is a significant reduction from the previous period where the number of falls was 17.

Over the last year, the following rates of falls were reported as NRIs:

DU Reportable Falls - Acute (YGC, WHM, YG)

DU Reportable Falls - Area (Central Area, West Area)

DU Reportable Falls - Specialist (MHLDS, Cancer Services)
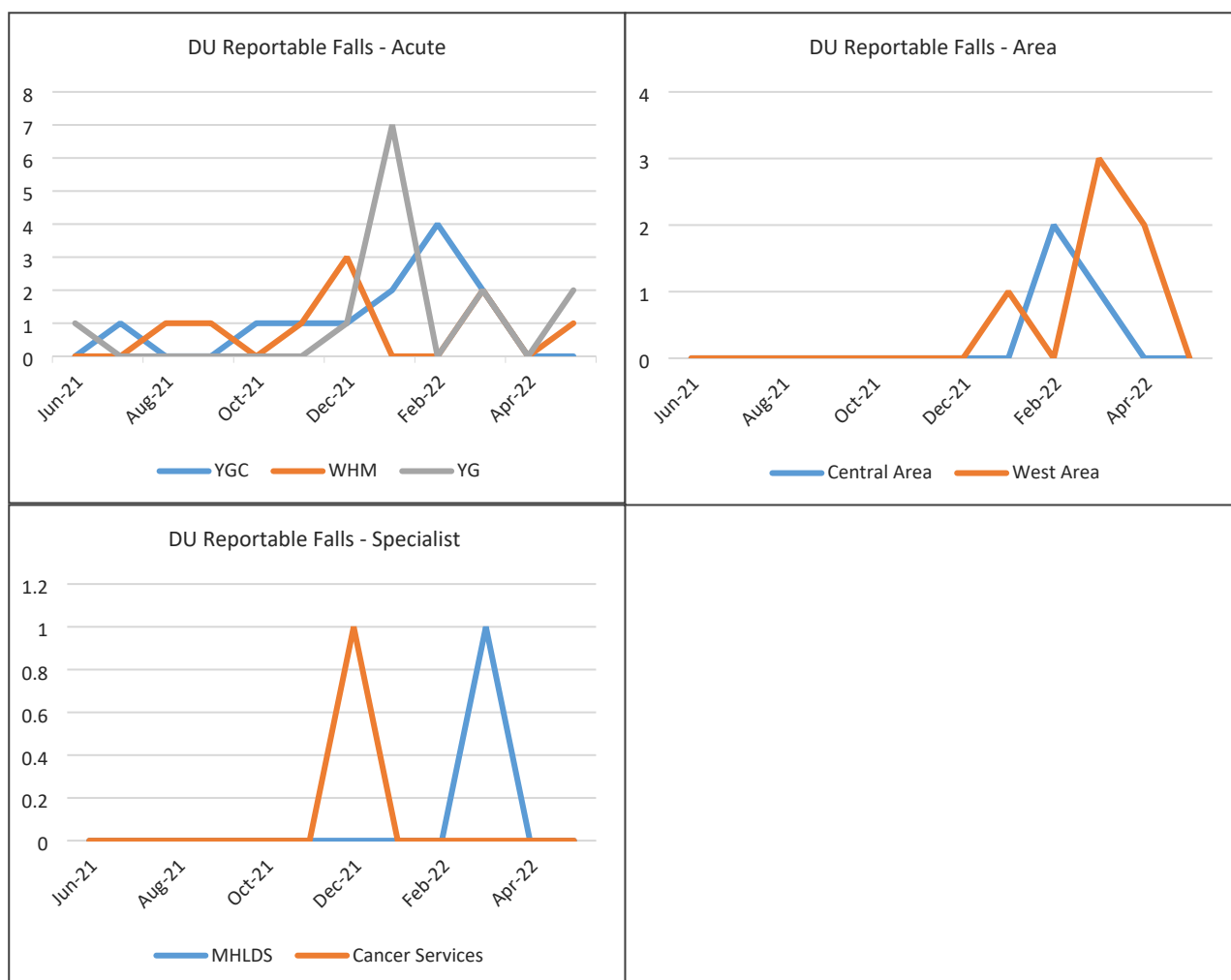
On review of initial learning from these incidents, there are ongoing themes that can be identified that contribute to these falls:

- Staff shortages
- Inadequate completion of falls documentation
- Poor handover/communication between staff or with families
- Lack of use of call bells
- Reliance on alarm equipment
- No lying and standing BP taken

Immediate actions include localised training and the increasing of awareness through sharing incidents details. The impact of this awareness and training is then monitored and measured through the ward accreditation process.

There were 6 investigation reports relating to falls during this period that were approved following a review at the Incident Learning Panel.

A specific paper was provided to the QSE Committee in March 2022 on performance and the improvement work being done. This included re-commencing the improvement collaborative model, new e-learning and updating the policy. The early indications of the pre-COVID Falls Collaborative were extremely positive. Building on this, a proposal paper is with the Executive Director of Nursing and Midwifery to establish a falls project, aligned to the Patient Safety Programme, and operating within the Health Board's quality improvement

methodology. This work will be overseen by a reformed Strategic Falls Improvement Group underpinned by health community working groups. Locality workshops are being arranged to take this forward. The application of the collaborative approach by each health community (as opposed to stand alone improvement teams) is envisaged will support rapid improvement across the complexities of each health economy whilst providing opportunity for local quality improvement to develop with the common language, skill and tools. Project plans will be developed with clear measures.

A number of specific improvement actions have been implemented:

- The Multi-Disciplinary Team (MDT) Model of upskilling staff 'bedside learning', with risk assessment completion and accurate intervention will be implemented with pace across inpatient areas and has been received positively by the HSE.
- E-learning modules continue to increase in percentage of completion across HB currently: module 1a is at 70% mandatory for all staff in BCU, module and 1b at 71% for all Patient facing clinical staff on Adult inpatient wards. To note: ward teams are mostly above the Health Board standard of 85%.
- The self-assessment tool developed to assess where wards, departments and divisions are against the approved Falls Policy (NU06) for each health economy has had a first test completed. The tool has been refined and tested in a further area this will be the mechanism for reporting and focusing on the basic evidence-based areas first for improvement in the new heath economies. Feedback received so far is that the tool has given clear focus on areas for improvement in terms of policy and deliverables·

Datix data is not pulling through into Health Board warehouse. This is a national issue with no fixed timeline available. A short-term fix is being explored with the Datix Implementation Team to build a report that wards can easily access to retrieve their data which almost replicates the information on the NIIP. This will only be short term fix falls will be competed first followed by HAPU and medication

Grade 3 or above healthcare associated pressure ulcer (n=3)

Within the reporting period there were a total of 3 grade 3, grade 4 or ungradable healthcare associated pressure ulcers.

Over the last year, the following rates of HAPUs were reported as NRIs:

DU Reportable HAPU - Acute
YGC · WHM · YG

DU Reportable HAPU - Area
Central Area · East Area · West Area
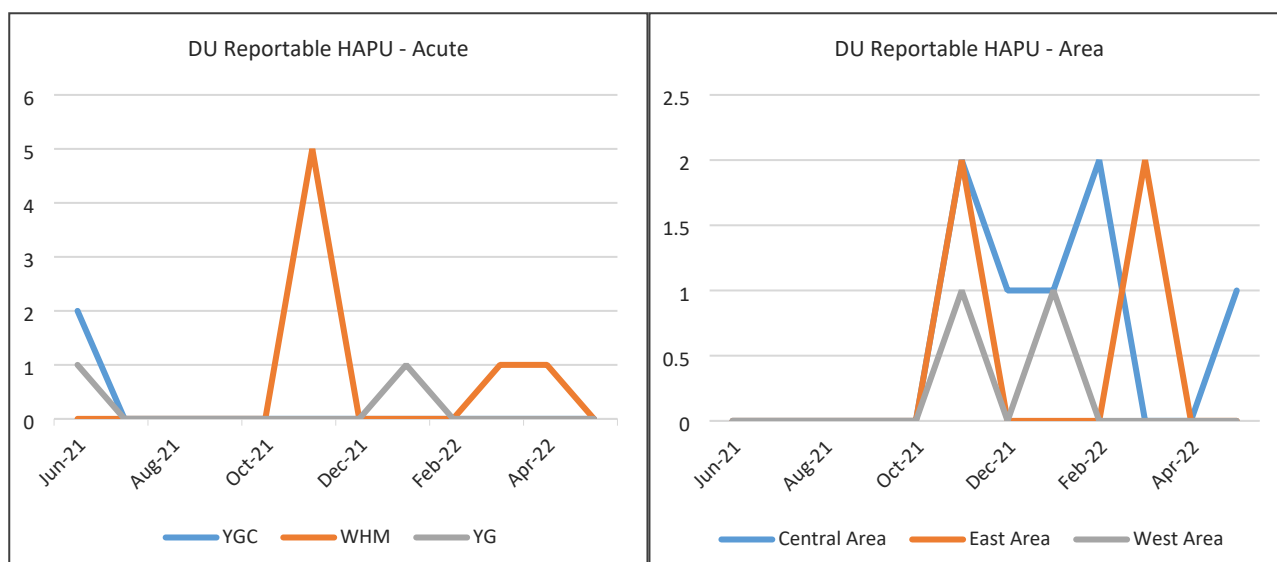
The recurring themes are:

- No evidence of increasing intentional rounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation

All investigations from pressure ulcer investigations are reviewed weekly at local harms' meetings. In addition, the sharing of findings at local level is reflected through the raising of awareness at safety briefs. The impact of the increased awareness is then monitored and measured through the ward accreditation process.

There were 4 investigation reports approved at ILP relating to reportable, avoidable pressure ulcers during this period. Themes and trends have been identified, which are as follows:

- No evidence of increasing intentional rounding as/when needed
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

A specific paper was provided to the QSE Committee in March 2022 on performance and the improvement work being done. This included re-commencing the improvement collaborative model which were suspended during the pandemic. As with falls, this will consist of health community improvement work feeding into an organisation wide strategic group using the Health Board's quality improvement methodology. Project plans will be developed, with measures, at both health community and organisation level. This work will form part of the overarching Patient Safety Programme which is detailed later in this report. Locality workshops are being arranged to take this forward.

A paper has recently been shared with the Interim Executive Director of Nursing and Midwifery that proposes a collaborative approach to harms and prioritises HAPUs. A draft improvement plan has also been shared and once approved, a workshop in each of the three Health Economies will be set up, with the over-arching aim to be agreed. A HAPU Strategic Committee will supervise local HAPU improvement work.

<u>Surgical safety</u>

Within the reporting period, zero incidents were nationally reported related to surgical safety.

Over the last year, the following rates of surgical safety incidents were reported as NRIs (excluding never events which are detailed in the specific section later o the report):
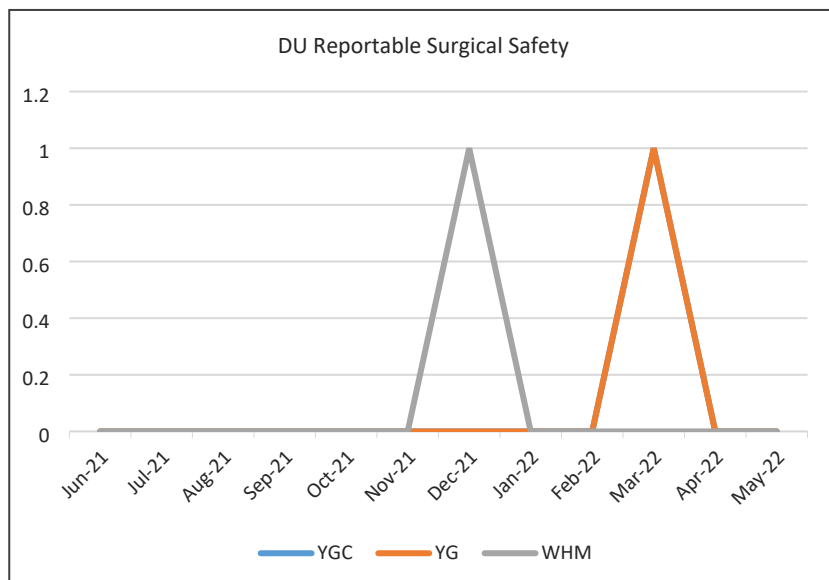
In response to the number of surgical safety incidents (including Never Events), and the learning identified, the Health Board recognised the role of human factors in the prevention and mitigation of systemic failure on patients, families and clinical staff. The Health Board aims to mainstream human factors knowledge, understanding and practice in order to ensure the consistent, sustainable delivery of safer care for patients, whilst supporting our staff in that delivery: *making it easy for them to do the right thing.*

To do this, the Health Board has (1) commissioned an external company with human factors expertise, AQuA, to build capacity and capability in human factors and its application to healthcare and training for cohort 1 (of 3) has commenced, (2) commenced the development of an organisational wide faculty dedicated to human factors, and (3) commenced a targeted programme into the surgical safety checklist.

To support (3) the Transformation and Improvement Directorate has recruited a Quality Improvement Fellow (which is a substantive member of the Patient Safety Team now on secondment). To date the QI Fellow has facilitated initial introductions and team engagement session, establishing the rationale, aims and timescales of the programme

A process mapping session was held, the goals of which were to:

- Visualise the '5 Steps to Safer Surgery' journey and pinch point bottlenecks and constraints to the 'Perfect' Checklist process and identify areas witnessing reduced engagement.
- PDSA cycle and brainstorming sessions undertaken, where low risk, quick win ideas were suggested for trial within the team Benchmarking of pan BCUHB and NHS England WHO Checklists'.

- Discuss around potential simulation and education sessions for clinical governance days.
- Review of proposed LocSSIP 69 '5 Steps to Safer Surgery – The WHO Checklist'.
- Creation of observation tool for the project team to collate data across all theatre specialties.

As well as focussing on service improvements, the application of human factors can also enhance and supplement traditional investigation techniques. The human factors programme supported by AQuA will develop our staff in the use of human factors at both an expert and practitioner level, and it is planned that staff who attend will also contribute to patient safety incident investigation teams.

The learning from one specific surgical safety incident previously reported to the Committee is highlighted below:

Total spinal anaesthetic

A patient had a cardiovascular collapse and loss of consciousness following insertion of an epidural for labour analgesia. The baby was born by emergency caesarean section. The mother developed posterior reversible encephalopathy syndrome (PRES) (7) and the baby had grade 2 hypoxic ischaemic encephalopathy (HIE). The mother needed care on the critical care unit in Ysbyty Gwynedd and the baby was transferred to the Sub-Regional Neonatal Intensive Care Unit (SuRNICC) at Ysbyty Glan Clwyd for treatment.

In response, the following actions are being taken forward:

- A standard operating policy will be written covering the responsibilities of the out of hours Consultants on-call and resident anaesthetists, relating to out of hours requests for epidural analgesia for labour, when the resident obstetric anaesthetist will not be available for at least 30 minutes following a request.
- The existing 'BCUHB – West Written Control Document for Establishing Epidural Analgesia for Labour' will be amended to include (amongst other recommendations) the following protocol -Instructions for the anaesthetist and anaesthetic assistant to remain in the labour room for the first 5-minute period following epidural test dose administration, to observe the patient for any developing signs of spinal anaesthesia.

Other new incidents not associated with the themes (n=1)

In addition to the above themed areas, the following incident is highlighted for the Committees' awareness;

- Incident arising from a delay in transfer to Ysbyty Glan Clwyd for treatment for vascular services. There is ongoing work between the Emergency Departments and WAST an ACCTS (Acute Critical Care Transfer Team) to review the intra/inter hospital transfer process to develop pathways for the transfer of patients who require time critical treatment.

Learning from other key incidents not associated with the themes (n=5)

<u>Delay in diagnosis on cancer</u>

Patient was referred by his dentist to the Oral and Maxillofacial Team as a USC case due to an intra oral swelling. A black and white clinical photograph accompanied the referral. This referral was triaged as 'urgent to be seen within three weeks.' There were delays in diagnosis due to cancellation of the appointment by the hospital. The patient was subsequently diagnosed and needed surgery and rehabilitation.

In response, the following actions are being taken forward:

- Weekly USC and Urgent waiting times report shared with Clinical Teams;
- Triage stamp to include priority and type of clinic appointment required;
- Safety netting by the patient booking team who review referral and waiting times and highlight to the surgical operational team if there are patients awaiting a specific timeframe appointment and if this target was not going to be met.

<u>Delay in review of investigations (Emergency Care/Vascular)</u>

Patient attended ED (Emergency Department) via Welsh Ambulance Service following fall at home and injury to right leg. Whilst patient was triaged in a timely manner appropriately and categorised as an amber patient, full review from a clinician was not undertaken until the following morning. This caused delay in referral to vascular surgeons at YGC (Ysbyty Glan Clwyd), given the diagnosis of an ischaemic limb post clinician review and subsequent CT scan. Patient was subsequently transferred to YGC. Surgery of a right knee amputation was undertaken.

In response, the following actions are being taken forward:

- Improve handover process between emergency department staff to include potential patient diagnosis, and monitor compliance with this;
- Remind referrers of their responsibility regarding justification for radiological investigations, of the IRMER regulations;
- Implement a robust system for referral to the on call vascular surgeon and actions to take if unable to contact and ensure all staff involved in referral are aware of the system.

<u>Delay to act on adverse symptoms</u>

Patient was conveyed by ambulance to Wrexham Maelor Hospital emergency department. Patient arrived at ED at 13:41 hours with a presentation of feeling unwell, with paramedics concerned that the patient was suffering with sepsis. The department was at full capacity, with numerous ambulances being held outside and therefore there was delay in the patient being brought into the department and subsequent diagnosis and treatment of sepsis. Patient was later transferred to surgical ward, but sadly passed away.

In response, the following actions are being taken forward:

- Review of SOP for management of patients in ambulances;
- Staff allocated daily to undertake investigations on ambulances ;

- Ambulance assessment room created (temporarily, whilst awaiting funding for permanent room within ED);
- Funding being sourced for permanent development of Ambulance assessment room in the ED.

Failure to follow up (Ophthalmology)

The patient was last seen on in April 2019 and was advised that he needed a six-month follow up appointment. However, the patient did not receive his follow-up appointment and he was then only seen in December 2021. During this consultation unfortunately there was evidence of significant visual loss. The Consultant confirmed that there was a permanent visual loss in the patient's left eye because of the progression of glaucoma, However, this damage could have been picked up earlier and treated if he had been seen on a six-monthly basis as per protocol.

In response, the following actions are being taken forward:

- Develop a Standard Operating Procedure to address the recording of the patients on the waiting list. To ensure utilising WPAS as the predominant method of managing patients on the waiting list and attendance;
- Undertake a Clinical Risk Assessment on social distancing measures at Abergele Hospital to increase face to face clinic appointments;
- A review of overdue follow-up appointments from the April 2019 to provide assurance no further patients are lost to follow-up and assess the numbers who may be overdue and by how long;
- Urgent additional clinics led by Clinical Fellows in the first instance to be arranged to increase capacity - likely to be run at the weekend/twilight;
- Business case for a Speciality Glaucoma Doctor and position filled by August 2022.

Unexpected death/Suicide (Mental Health)

The Community Mental Health Team (CMHT) were informed of patients' sad death on the by the criminal justice liaison service. Patient death was unexpected. Patient had been known to Mental Health Services since April 2020.

In response, the following actions are being taken forward:

- Team debriefs and reflective discussion to be undertaken collaboratively by both CMHT and HTT;
- HTT to review Triage process and to incorporate Telephone assessments in exceptional circumstances.

NEVER EVENTS

In total, twelve Never Events have been reported in 2021/22 (compared to five in 2020/21 and six in the full year of 2019/20). Action relating to the primary theme (11 of 12 incidents) is surgical safety, which is detailed above in the learning and improvement action.

No. Never Events (Incident Date)

Legend:
- WHM - Anaesthetics
- WHM - Gynaecology
- WHM - Obstetrics
- Abergele - Ophthalmology
- Abergele - Trauma/Orthopaedics
- YGC - Critical Care
- YGC - Emergency Department
- YGC - Respiratory Medicine
- YGC - Trauma/Orthopaedics
- YGC - Vascular Surgery
- YG - Emergency Department
- YG - Gastroenterology
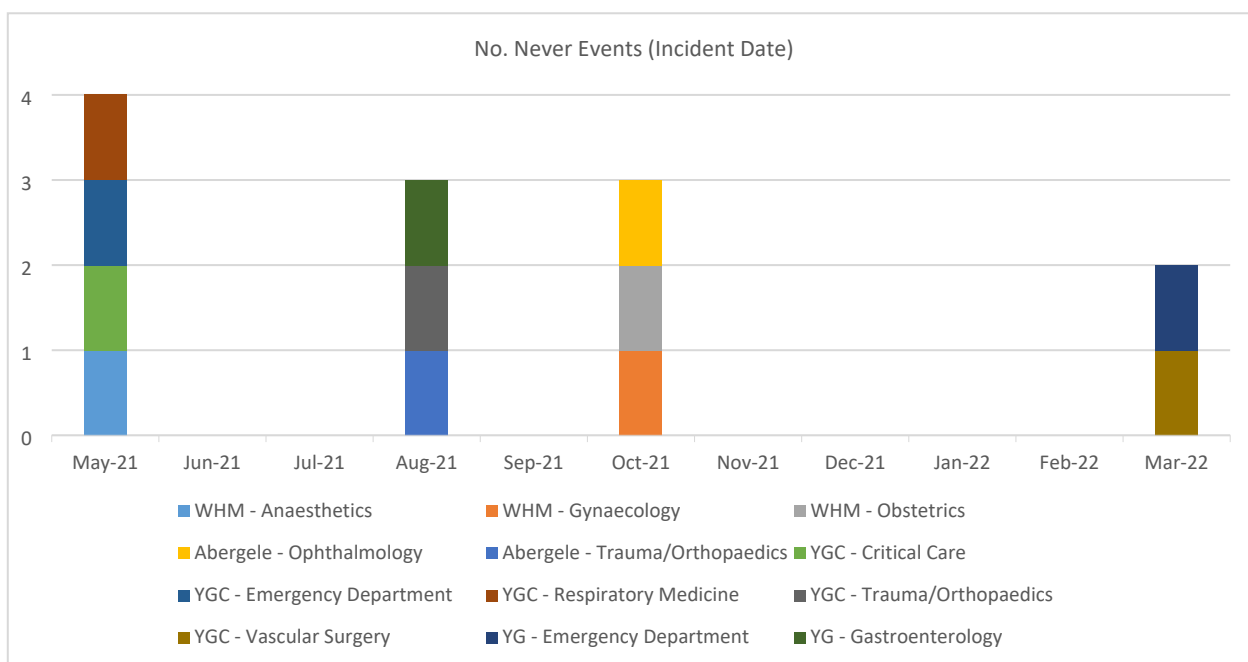
New Never Events

There were no new Never Events reported during April and May 2022.

Open Never Event Investigations

The following Never Event investigations remain underway.

Incident date	Incident Description	Current status
Retrospective incident 10/05/2021	Retention of a foreign object – a surgical swab found within the patient's throat following a theatre visit.	The investigation is in the final stages of investigation.
20/08/2021	Ascetic drain inserted inappropriately. Consent taken from patient as intended to relieve respiratory symptoms.	Rejected at ILP – more robust action plan required.
22/08/2021	Patient underwent surgery to fix left proximal humerus fracture, during surgery the small guide for philos plate used was left in situ. The day after surgery, a check x-ray revealed the issue after being also alerted by HSDU to the absence of the small block.	The investigation is in the final stages of investigation.
13/10/2021	During laparoscopy for ectopic pregnancy, healthy tube removed prior to visualisation of rupture tube containing pregnancy.	Investigation completed – awaiting action plan.

06/03/2022	Wrong site surgery – patient taken to theatre for a femoral - popliteal bypass but received a femoral - femoral bypass only.	Investigation ongoing.
18/03/2022	Wrong site surgery – Patient taken to theatre for laparotomy and litigation of right iliac artery. Further exploratory laparotomy undertaken where the surgeon removed vicryl tie around left common iliac artery.	Investigation ongoing.

INDEPENDENT INVESTIGATIONS

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

Location	Incident	Update
CMHT (East) MHLD	Patient known to Community mental health team arrested on suspicion of murder	The draft report has been received for an accuracy check. Child and Adolescent Mental Health Service (CAMHS) have requested further clarity and accuracy changes. The final report is expected to be received by mid July 22

PATIENT SAFETY IMPROVEMENT PROGRAMME

The Quality Directorate are currently working closely with the Transformation and Improvement Directorate to develop a **Patient Safety Improvement Programme**. A workshop was held on 07 February 2022 led by the Associate Director of Quality. All medical, therapy and nursing directors were invited, and the aim of the workshop was to work through priorities for the projects (approximately 4/5 per year) focused on preventing or reducing harm. The recommendations were presented at a meeting with the Executive Clinical Directors and a paper on the programme structure is being drafted for submission to the Executive Team.

These five priority projects proposed, linked to the themes that are highlighted in this report, are:

- Deteriorating patient
- Falls
- Healthcare Acquired Pressure Ulcers (HAPUs)
- Surgical Safety
- Clinical documentation

PATIENT SAFETY ALERTS AND NOTICES

The Welsh Government (WG), supported by the NHS Wales Delivery Unit, leads on the vital role in identifying significant national safety risks and concerns that would require a Patient Safety Solution at a national level for issue to the NHS in Wales. There are two types of solutions issued:

- ALERT (PSA): This requires prompt action with a specified implementation date to address high risks/significant safety problems.
- NOTICE (PSN): This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas and take immediate action. This stage 'warns' organisations of emerging risk. It can be issued in a timely manner, once a new risk has been identified to allow rapid dissemination of information for action.

Organisations are required to confirm that they have achieved compliance by the date stated.

Open Alerts

Reference	Title	Applicable To?	Type	Date action underway	Deadline	Notes
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	BCU-wide	Patient Safety Solution - Notice	27/05/2021	31/12/2021	SOP developed with specialty consultant and medical director - to be approved through governance structure by Mid July.
PSN058	Urgent assessment/ treatment following ingestion of super strong' magnets	BCU-wide	Patient Safety Solution - Notice	13/07/2021	05/10/2021	Closure due end June – evidence being evaluated.

Closed Alerts

No PSA/PSN were closed in this time period.

DATIX CYMRU

The new Datix Cymru system was launched across the Health Board on 01 April 2022. This system is in use across Wales and aims to bring consistency to reporting across all Welsh Health Boards and Trusts.

The Datix Implementation Team have been working to a clear project plan and provided significant training opportunities and extended helpdesk support during implementation.

As with the introduction of any new system, there were issues and challenges that evolved. Initial issues included:

- Access to Datix: Issues have been resolved as over time the implementation team have amended permissions and/or "location exact" in order for users to access all reported complaints and incidents in specific user areas of responsibility.
- There are some ongoing issues such as the Mortality process and system flow that does not follow the Health Board process. Members of the Datix Implementation Team are attending Once For Wales task and finish group to match the framework to the module.
- Migration of open Incidents, claims and inquests is ongoing from the Datix web system.

There are no fundamental issues remaining for escalation to the committee; however, as a new national project with ongoing development and further projects, the continued development and roll out is being carefully supported and managed locally.

LITIGATION

During this bi-monthly period of April and May 2022, 54 claims or potential claims were received against the Health Board. Of these, 44 related to clinical negligence and 10 related to personal injury.

Whilst the numbers have fluctuated a little throughout the bi-monthly periods, it is anticipated by Legal and Risk Services (the Health Board's solicitors) that claims will rise significantly due to the direct and indirect effects of the Covid-19 pandemic. The number of new claims received has fluctuated over the last two months, which has been as expected and it is believed this figure will continue to rise as the Health Board begins to deal with the effects of cancelled procedures and appointments.

Personal Injury Claims-BCUHB starting 01/06/21
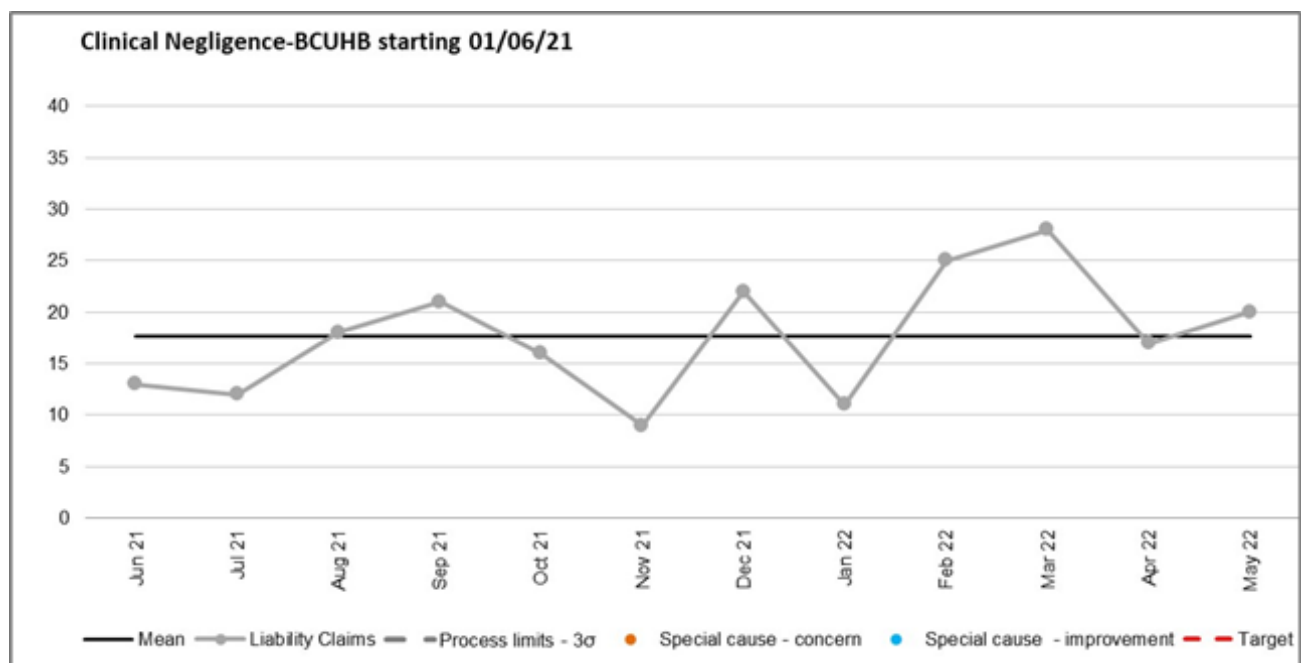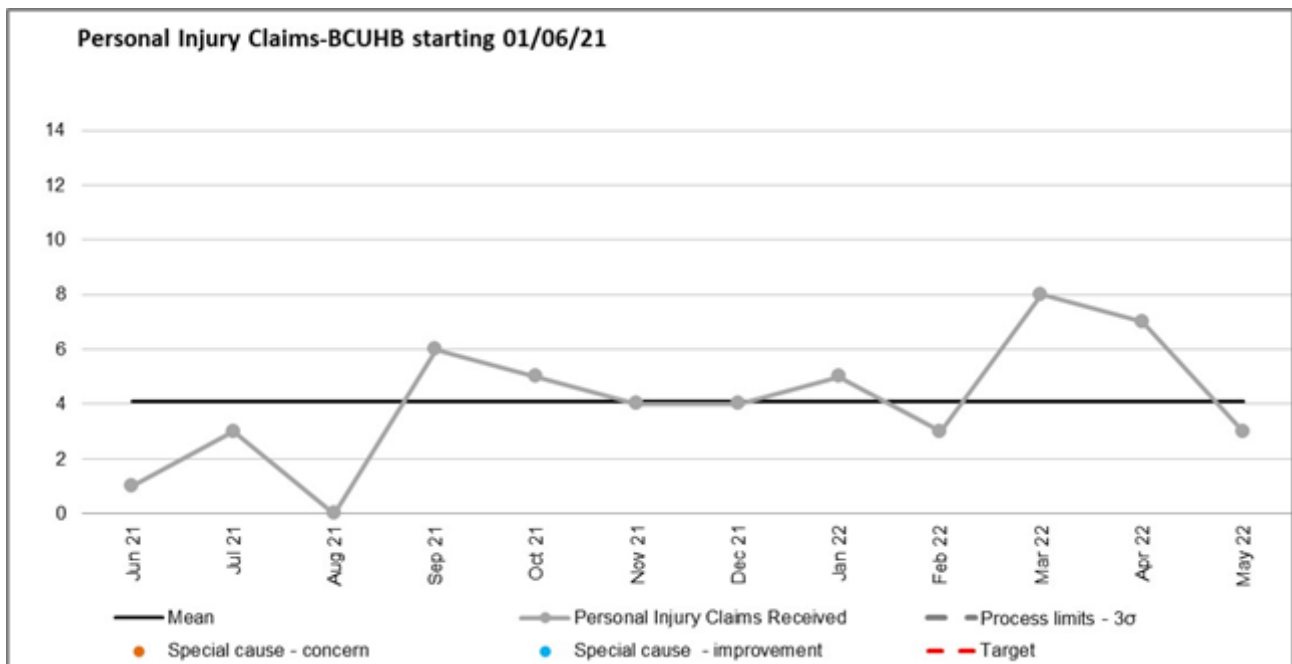
During the bi-monthly period, 92 claims were closed. Of these, 85 related to clinical negligence and 7 related to personal injury. This figure is higher than previous months as the team have been reviewing claims prior to migration to RL Datix and closing those that were limitation barred and dormant over 12 months. The total costs for these overall closed claims amounted to £2,233,625.33 before reimbursement from the Welsh Risk Pool. The most significant claims related to:

Failure to recognise/monitor developing ischaemia post arterial line removal and lack of Vascular Consultant on call cover. (£1,060,555.63)

Learning:

A documented arterial line bundle that includes elements for patient need, insertion and maintenance to be developed.

Patient monitoring is improved and the presence of an arterial line facilitates convenient and frequent blood sampling whilst preventing frequent venepuncture and its associated discomfort for the patient. The old pre-printed line insertion labels did not have the facility to record the time of insertion. This is to be amended to include the time of insertion.

Senior Staff for Critical Care will take lead responsibility for the implementation and monitoring of the action plan and will engage with other partners to ensure full implementation of the recommendations made within the final report.

A robust system for managing and communicating the on-call vascular rota has been developed.

<u>Failure in prescribing steroids to a patient with neurological issues on background of dental infection and a failure to refer to a dentist or Oral Maxillo-facial Surgeon. (£536,420.65)</u>

Learning:

Following review of this case a Standard Operation Procedure (SOP) has been created. This has been created in conjunction with BCUHB Dental Services in relation to treating dental patients in the Out of Hours Period. This SOP has been shared with all staff across the service.

<u>Perforation of the bowel which occurred during a vaginal hysterectomy anterior vaginal repair for prolapse procedure. Possible perforation should have been investigated sooner and surgery would have been performed within 24 hours. Issues were also identified with regards to completeness of records and appropriate documentation. (£237,876.89)</u>

Learning:

This incident was discussed at the Women's Quality, Safety & Effectiveness Sub-group in January 2021 to ensure learning has been shared across the Service.

The incident was also be discussed at the local Gynae M&M meeting to share the learning.

Training session held on 25th October 2019 with doctors for Women's where discussion was held on the importance of accurate documentation.

Record keeping is part of the doctors Induction Programme.

<u>Missed opportunity to perform successful revision thumb fusion surgery. There was a failure to recognise the significance of the movement felt intra-operatively at the right index (second) carpo-metacarpal joint ('CMCJ') and failing to associate the movement identified with persistent non-union. (£112,938.55)</u>

Learning:

The case was shared and discussed at the T&O clinical governance meeting. The learning was shared to raise awareness and to reduce the risk of this happening again.

<u>The claim relates to a right shoulder dystocia brachial plexus birth injury due to alleged mismanagement of the delivery. Although both midwives stated that the care given was appropriate and that that the manoeuvres were completed correctly and no fundal pressure was applied, we were unable to locate training records for the midwives, and show appropriate management of shoulder dystocia (£1,076,894.34)</u>

Learning:

An electronic database was established in 2014 to record compliance with mandatory training for both midwives, and obstetricians and all e-learning packages are now recorded on the Electronic Staff Record (ESR). It is therefore now possible to access compliance rates for Women's Services as required.

All midwives and obstetricians have been required to attend Practical Obstetric Multi-professional Training (PROMPT) annually, since its introduction in 2017. Within this training day, staff are required to participate in obstetric emergency drills, inclusive of shoulder dystocia, and the importance of avoiding downward traction when delivering a baby is highlighted.

PROMPT training also incorporates clinical leadership and situational awareness during an obstetric emergency, ensuring safe care provision.

The requirement for annual attendance at a PROMPT day is monitored and recorded by the Professional Development Midwife and compliance with the PROMPT standards is audited by Welsh Risk Pool.

There is also a Shoulder Dystocia Guideline available to support staff that details that 'routine traction in an axial direction (in line with the fetal spine) can be used to diagnose shoulder dystocia, but any other traction should be avoided.

Delay in diagnosis of non-invasive in-situ condition with Pagets Disease. The biomarker results from Cardiff were not reviewed in the diagnosis. (£271,526.17)

Learning:

Multi-head microscope sessions now take place with all Consultant Histopathologists for difficult to diagnose cases.

Verbal reports are no longer issued, and results are reported via Welsh Clinical Portal and via paper reporting sent directly to the requesting Clinician.

The process of printing and auditing paper reports has been updated to include an instruction that reports are sent to the requesting Clinician (or Secretary) not location. An audit has been put in place to ensure reports have been sent out.

Electronic report alerts was added to the Pathology risk register following this incident, and alerts are currently under development in Welsh Clinical Portal.

Failure to carry out colonoscopy by early April 2016 and failure to provide adequate pain relief in palliative care. (£115,251.10)

Learning:

Endoscopy to move to electronic referrals and booking system to ensure a slick process for getting patient appointments scheduled.

The following themes have been identified for this period for clinical negligence:

- Implementation of care
- Diagnosis – Including delay in diagnosis
- Treatment or procedure

As expected the largest number of open claims relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS. The themes remain similar. The Health Board also continues to comply with the Early Reporting Scheme adopted in Wales in relating to potential birth injury claims.

The following themes have been identified for personal injury:

- Slips/trips
- Violence & Aggression

Personal injury claims savings due to discontinued or favourable settlements for this period £129,589.40. These are financial savings for providing evidence to L&R, which allows for a denial of Health Board liability in a matter leading to a claim being discontinued or in the case of favourable settlements; we have been able to negotiate a lower compensation payment due to the investigative work of the Claims Manager (PI) and L&R.

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

The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure and that it is likely additional contributions will be required. BCUHB's share of the increase will be 17.07% and the current forecast predicts an additional cost of £2.56m in addition to the contribution already made, creating a significant impact on the overall financial position. The Finance Division are aware and it will be included as a potential risk until things are finalised later on in the year. National discussions are underway, however this figure succinctly reflects the increasing costs arising from liability claims across the NHS.

INQUESTS

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

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

During the relevant time period, April and May 2022, 65 new inquests or requests for information from the Coroner were received from the Coroners in North Wales.

New Inquests-BCUHB starting 01/06/21
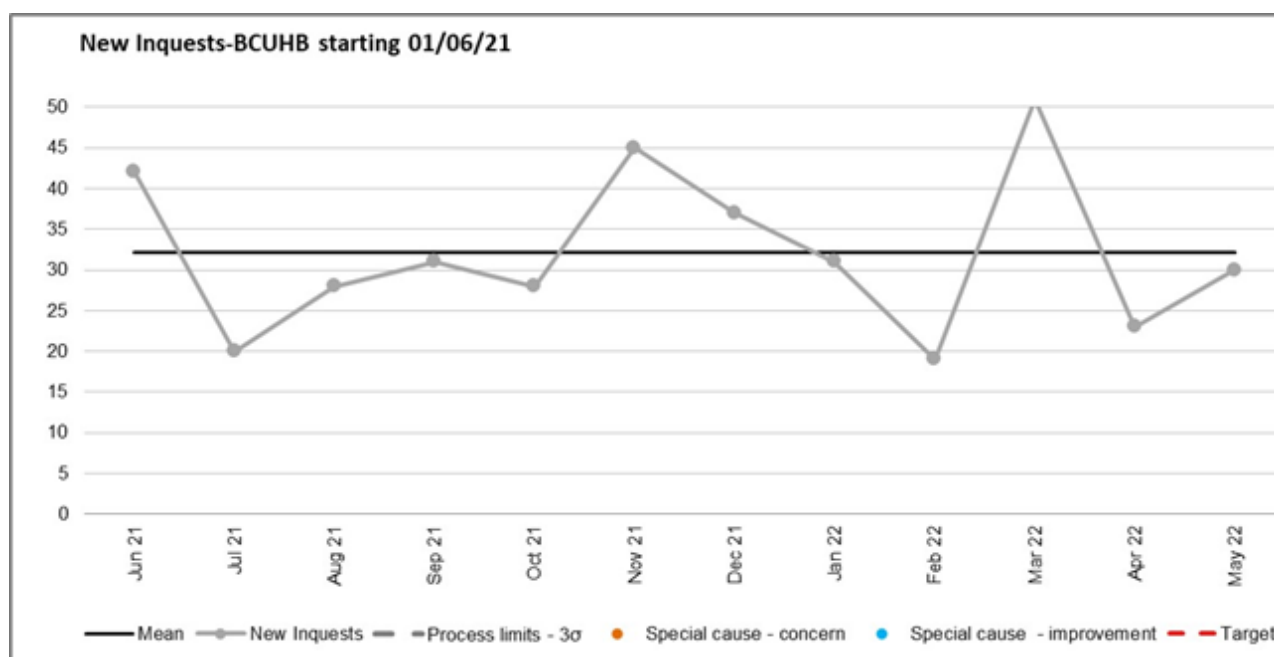
54 inquests were concluded between during April and May 2022 with the inquest conclusions (where they have been shared with the Health Board by the Coroner) shown below (not all inquest conclusions have been shared to date).

Inquest Conclusions where shared by HMC
(April & May 2022)
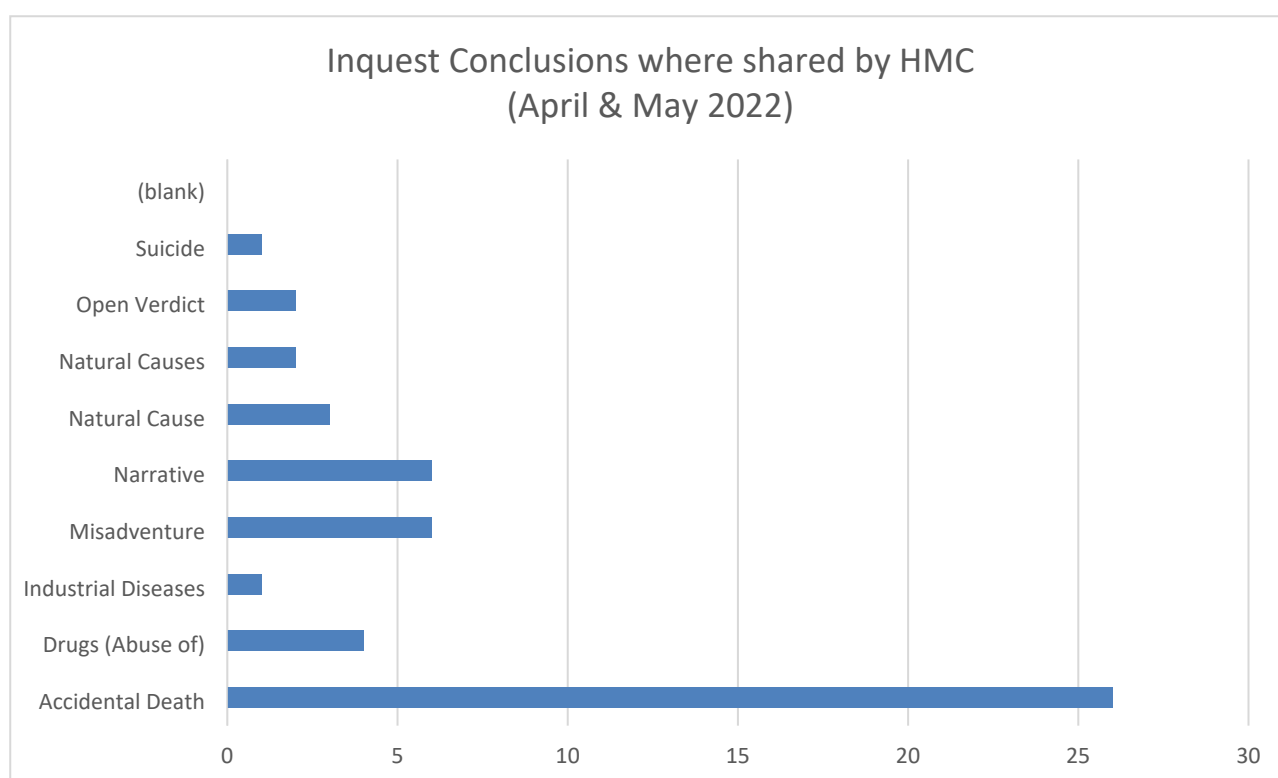
The distribution of these inquest conclusions is in line with previous findings, and there are no unusual or unexpected findings to be taken from this.

Regulation 28 (PFD)

In the period of this report, 3 new Regulation 28 (PFD) reports were received by the Health Board,

1 **NF: Medication reviews by ANP in community** (Inquest heard in February 2022 but Reg 28 report not received from HMC until April 2022)

Coroner's Concerns:
1. Despite discussion between the Advance Nurse Practitioners and Care Home staff, Levothyroixine was not restarted – and despite the deceased being seen on a further six occasions – there was no routine medication review to identify this omission.
2. Time constraints restricting ANP access of medication charts
3. The absence of proper consideration of patients' medication during each visit presents a risk to life as errors are not identified

Response: Response issued by Health Board on 10 June 2022 include the following actions:

- Review of best practice guidance for ANPs – for completion by 30 September 2022
- Rolling training programme facilitated by Medicines Management for all nursing and residential homes
- Introduction of local policy for documentation of medication review at each ANP visit to homes
- All district nursing teams will develop, review or adapt their SOP/checklist to meet the needs of their service and provide assurance of medication reviews
- Review of Medicines Policy (MM01) – for clarity in community settings – complete by 30 September 2022
- Business case for investment into Medication Administration Training for all residential and nursing home settings
- Audit of the existing rolling training programme to be developed – to identify homes where training is incomplete or out of date, to include a compliance matrix
- Welsh Government pilot project has been developed (for future implementation) with a view to community pharmacy carrying out medication reviews of patients in care homes.

2 **TR: Theme – delay providing evidence of completed actions post investigation / change in working practices**

Coroner's Concerns:

1. Despite earlier identification that existing working practices within Oncology (placement of report on clinician's desk) resulted in failure to treat in a timely manner, the Health Board did not fully implement a new SOP until December 2021.
2. Formal acknowledgement of new SOP by Oncology and Haematology secretaries not completed until 22 February 2022
3. Failure to have completed an audit process to assure changes were operational and effective.
4. The length of time taken to implement changes and ensure introduction and adoption of new, safe working practices presents a risk to life.

Response due with HM Coroner by 01 July 2022.

3 **RG: Theme – Ambulance delays**

Coroner's Concerns:

1. First cause of ambulance delay – all other resources already allocated
2. Delay in handover from WAST to BCUHB across all sites
3. Concern that future deaths will occur either with patients awaiting transfer into hospital from ambulance, or by ambulances not being available to meet community need.
4. These matters of concern are longstanding and despite proposed future action the concerns remain.

Regulation 28 PFD issued jointly to BCUHB and to WAST

Response due with HM Coroner by 20 July 2022.

Regulation 28 PFD reports received in the last year were summarised in the previous report.

In addition to the 3 Regulation 28 PFD reports listed above, the North Wales Senior Coroner has indicated that failure to submit completed investigation reports in a timely manner may incur further Regulation 28 PFD against the Health Board, even before the inquest is listed.

HEALTH INSPECTORATE WALES (HIW)

Health Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. HIW reviews and inspects NHS services in Wales, and regulates healthcare providers against a range of standards, policies and regulations to ensure they comply with regulations and meet the healthcare standards, highlighting areas of improvement.

HIW monitor the use of the Mental Health Act and review the Mental Health service to ensure that vulnerable people receive good quality of care in mental health services.

HIW are also requested by HM Inspectors of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.

The Health Board manages correspondence and inspections from HIW via an internal standard operating procedure.

All correspondence from HIW is received into the Health Board via the Chief Executive's Office or direct to the Quality Directorate (to a dedicated inbox) depending on the request i.e. inspection, request for information, raising of concerns. All correspondence to HIW follows a review and approval process from the service through to the appropriate director sign off, prior to submission. Monthly engagement meetings are held between the Health Board (the Associate Director of Quality) and an assigned relationship manager/team from HIW.

The Quality Directorate continues to capture and monitor HIW activity via the DatixWeb patient safety system, whereby action plans developed in response to HIW inspections and enquiries are inputted and assigned to responsible officers. Actions are followed up to completion, with the support of the Quality Assurance Team, and evidence supporting progress is uploaded. This enables an efficient and auditable process for regulatory activity and Health Board response, as well as an opportunity to provide regular reports.

The cloud based DatixCymru system that has been implemented as of the 1st April 2022 does not support HIW activity capture and management; discussions have been held with

the national Once for Wales Management System (OFWCMS) to address this deficit, but will not be realised within this financial year.

In the interim, the Quality Team are testing the AMaT system. The system was created with NHS clinical audit teams to give healthcare trusts more control over audit activity and to provide real-time insight and reporting for clinicians, wards, audit departments and trusts. The inspection module within AMaT has been built to capture inspections and will therefore ensure that Healthcare Inspectorate Wales activity is recorded, tracked and will assist with future reporting and providing assurance.

In May 2022 the inspections covered the following areas:

Service Requiring Significant Improvement:
Emergency Department, Ysbyty Glan Clwyd, May 2022

On the back of the inspection in March, HIW undertook an unannounced inspection of the Emergency Department at Ysbyty Glan Clwyd between 03 - 05 May 2022. During the quality check HIW found immediate assurance improvements were required around timely access, record keeping, managing risk, medicine management and governance and leadership. An Immediate Assurance Improvement Plan was submitted to HIW for assurance.

Consequently HIW considered their findings and evidence following a No Surprise Notification in January along with the inspection in March and May 2022. HIW has determined that the Health Board has not been able to demonstrate sufficient progress against several key areas of concern relating to patient safety and quality of care.

The Emergency Department at Ysbyty Glan Clwyd was considered and consequently identified as a Service Requiring Significant Improvement.

The service remain under this status until such time that HIW de-escalate the service from this status. The Health Board await further details from HIW in terms of their planned approach to this.

The inspection report from March was published by HIW on 18 May 2022 and can be found at **Appendix 1**.

Jo Whitehead, Chief Executive, issued a statement to the media and public in response to the notice of Service Requiring Significant Improvement.

The Quality Team have scheduled regular quality reviews with members of the Hospital Management Team (HMT). Since the week commencing 6 June 2022, these reviews have been conducted daily as more focus is required to ensure that significant progress is made and assurance provided to the Board, HIW and Welsh Government.

In line with internal HIW protocol and to assist with the quality reviews, data from the inspections has been extracted from the DatixWeb system into a tracker which presents the progress made against each of the HIW Recommendations, and evidence provided to date. The Quality Team have assisted the HMT with collating evidence in order to progress at a timely pace. The current status of the actions are located in 'Action Status' table below.

The tracker also identifies gaps i.e. where evidence has not yet been provided. For those actions where gaps are identified, the Quality Team and Nursing Assurance Team are providing further support and advice.

The Quality Team plan the following by the end of June;

1. The Corporate Nursing Assurance Team will visit the Emergency Department to assist with audits for collating evidence where there are gaps identified.
2. A further ward accreditation visit will be scheduled. This will help to determine if the changes made so far, have made the required improvements.
3. The Quality Team will support the appointed HMT work stream lead (Director of Operations) for the improvement work to ensure that an improvement plan is in place, and a collaborative approach is taken with key colleagues, to include Transformation and Improvement.
4. The Quality Team will schedule further quality reviews with the lead and key colleagues to ensure support and continuous review of the improvement work.

Strengthening the improvement work is a Patient and Carer Experience Engagement Plan which aims to improve Patient and Carer Experience at Ysbyty Glan Clwyd Emergency Department with the following key objectives;

- To work with Emergency Department staff at Ysbyty Glan Clwyd to increase patient and carer feedback.

- Implement learning and service improvement from Patient and Carer experiences.

- Identify training needs and implement appropriate awareness sessions to help improve patient and carer experience.

- Engagement weeks - undertake patient experience improvement actions identified by the Emergency Department and data gathered throughout this time.

- Evaluate data gathered in collaboration with Emergency Department staff, share learning and good practice.

The feedback is collated in many difference ways and includes a regular presence from the Patient and Carer Experience Team in the Emergency Department. Improvements have already been suggested by the team and work is underway to implement the improvements with the HMT.

HIW Improvement work

HIW activity including improvement plans are captured on the Datix system. The Quality Team work collaboratively with senior leaders across the Health Board to ensure SMART actions and ownership of improvement work, helping to support the culture for learning and improvement and to provide assurance to stakeholders and to the Board.

Actions status

Inspection	Date of inspection	Action Status			Total
		Implemented	**In Progress**	**Overdue**	
WAST Review	September 2021	In progress			19
National Review of MH crisis prevention in community	April 2021	In progress			19
Emergency Department, YG	March 2022	20	0	9	29
Emergency Department, YGC	March 2022	45	5	5	55
Emergency Department, YGC	May 2022	19	8	20	47
Hergest Unit, Ysbyty Gwynedd	September 2021	76	0	2	78
Tan y Coed, Bryn y Neuadd Hospital	November 2021	9	1	0	10
National Review of Patient Flow	December 2021	7	4	3	14

Key themes/findings

It is important to note that many of the actions or improvements arising relate to the Health Board providing safe and effective care and timely care. The most common Health and Care Standards themes which relate to the actions noted in the table above are as follows;

- Safe and Clinically Effective Care
  - Managing risk and promoting health and safety
  - Medical devices, equipment and diagnostic systems
- Timely Care
  - Timely access
- Staff and Resources
  - Workforce
  - Staff wellbeing
- Effective care
  - Record keeping

Concerns, enquiries and requests for information

As well as formal inspections, the Health Board has also received a number of concerns raised by staff and patients/carers to HIW, as well as information requests following the submission of Early Warning Notifications to Welsh Government and deaths in custody health record requests. These include staffing issues, access to services, safety incidents and safeguarding concerns. All concerns/information requests are responded to through the established process.

Table 2

Concern	Summary of concerns	Response submitted to HIW	Status of Actions
Hebog Ward, YG	Patient's family raised concerns to HIW around care afforded to the patient while on the Ward.	May 2022	**In progress**
Dinas Ward, Ablett Unit MHLD	Patients family raised concerns to HIW around patients leave under the Mental Health Act requirements	May 2022	**In progress**

HIW have been focussing a number of questions around timely access with specific interest in patient experience, delivery of safe and effective care and quality of management and leadership.

The Quality Team have scheduled Progress Review meetings with key leads to ensure that any actions agreed as a result, are on track and making the required improvements. Progress is to be reported to this group, as with other HIW activity.

CONCLUSION

This report provides the Quality, Safety and Experience Committee with information and analysis on patient safety including Nationally Reportable incidents and Never Events occurring in the last two months. This report also provides detail of Healthcare Inspectorate Wales activity for May/June 2022.

The QSE Committee is asked to note the report.

Quality Check Summary
Ysbyty Glan Clwyd (Emergency Department)
Activity date: 8-10 March 2022

Publication date: 18 May 2022

This publication and other HIW information can be provided in alternative formats or languages on request. There will be a short delay as alternative languages and formats are produced when requested to meet individual needs. Please contact us for assistance.

Copies of all reports, when published, will be available on our website or by contacting us:

In writing:

Communications Manager
Healthcare Inspectorate Wales
Welsh Government
Rhydycar Business Park
Merthyr Tydfil
CF48 1UZ

Or via

Phone: 0300 062 8163

Email: hiw@gov.wales

Website: www.hiw.org.uk

Quality Check Summary

Our approach

Healthcare Inspectorate Wales (HIW) undertook a remote quality check of the Ysbyty Glan Clwyd Emergency Department as part of its programme of assurance work. Ysbyty Glan Clwyd forms part of Betsi Cadwaladr University Health Board.

HIW's quality checks form part of a new tailored approach to assurance and are one of a number of ways in which it examines how healthcare services are meeting the Health and Care Standards 2015.

Feedback is made available to service representatives at the end of the quality check, in a way which supports learning, development and improvement at both operational and strategic levels.

Quality checks are a snapshot of the standard of care within healthcare services. They are conducted entirely offsite and focus on three key areas; infection prevention and control, governance (specifically around staffing) and the environment of care. The work explores arrangements put in place to protect staff and patients from COVID 19, enabling us provide fast and supportive improvement advice on the safe operation of services during the pandemic. More information on our approach to assurance and inspections can be found here.

Where urgent action is required following an NHS quality check, we issue an Immediate Assurance letter to the Chief Executive of the organisation within two working days. This requires the setting to undertake immediate improvements to maintain patient safety.

As part of our Quality Check, we spoke to the Charge Nurse and Matron on the 8th March 2022, the Head of Nursing, and Clinical lead on 9th March 2022 and Band 5 and 6 department staff on 10th March 2022 who provided us with information and evidence about their service. We used the following key lines of enquiry:

- **How do you ensure that the environment is safe for staff, patients and visitors and that it maintains dignity and provides comfort for patients?**
- **How the staff management and governance arrangements ensure that the department is able to provide care that is safe and effective?**
- **How do you ensure that the flow of patients through the department is effective and that patients changing needs are assessed to identify acute illness and keep patients safe?**
- **How do you ensure that patient discharge arrangements are safe, including those patients presenting from vulnerable groups?**

We issued an Immediate Assurance letter on 14 March 2022 due to issues listed below. The health board responded on 22 March 2022 with a full action plan to address the issues raised. We acknowledged the progress made to date, but also that some issues would take some time to address. We plan to have regular engagement with the health board as it progresses the actions necessary to ensure patient safety.

Environment

During the quality check, we considered how the service has responded to the challenges presented by COVID-19 and how the service has designed and managed the environment of care to keep it as safe as possible for patients, staff and visitors. To do this we undertook a review of 20 sets of patient clinical records.

We also questioned the service representatives on the changes they have made to make sure patients continue to receive care and treatment according to their needs.

The following positive evidence was received:

We were informed by staff that on entry to the Emergency Department there is a member of security staff alongside a healthcare support worker. The healthcare support worker's role is to screen and swab each patient for COVID-19 before permitting entry into the department. We were told by staff that currently the waiting area has a separate area for those with any COVID-19 symptoms.

The staff informed us they have the ability to allow patients who are being discharged from the department during the hours of 8:00am and 8:00pm to wait for transportation in the discharge lounge, which is located on the hospital premises. However, outside of these hours there is no area in which patients can wait other than within the department.

Staff informed us of arrangements in place for families and carers to support vulnerable patients with their care and treatment when they attend the department. Staff told us that patients who are considered to have a cognitive impairment are permitted to have a family member or carer present with them. We were also informed that the Red Cross are situated within the department and, if capacity allows, they can assist vulnerable patients. The Red Cross also offer soft drinks to patients, and often assist in providing transportation of patients on discharge.

We were informed by staff that each entry door in the department is accessed using a swipe identification card in order to ensure that only people with authorised access can access the clinical areas of the department. Staff also informed us that in order to access the paediatric clinical area there is a separate door which requires staff to again swipe their identification

card.

The following areas for improvement were identified:

We were informed of the arrangements for monitoring patients within the adult waiting areas. Patients with 'major' presentations (patients who would require a trolley in the majors area if available) were routinely accommodated in the waiting room while waiting to be seen.

These patients were not subject to any consistent or ongoing checks, or monitoring of their condition. This included patients with infections, mental health problems and significant head injuries.

This lack of oversight also meant that high risk patients could leave the waiting area unnoticed. In our review of 20 cases, absence was not noted in several cases until many hours later, at which point the patient may have been at significant risk of deterioration.

There were no clear lines of accountability and responsibility for the waiting areas, with arrangements for checking the area currently being ad-hoc and inadequate.

Overall, the arrangements for monitoring patients in the adult waiting areas were insufficient and meant patients were placed at risk of avoidable harm.

The health board should ensure that robust arrangements are in place to oversee, monitor and escalate patients who are located in the waiting areas. This improvement was raised as an issue requiring immediate assurance from the health board.

Infection Prevention & Control

Infection Prevention and Control

During the quality check, we considered how the service has responded to the challenges presented by COVID-19, and how well it manages and controls the risk of infection to help keep patients, visitors and staff safe.

The key documents we reviewed included:

- Environmental Infection Prevention Control Audit
- Mandatory Training record
- Hand Hygiene Audit
- COVID screening form.

The following positive evidence was received:

Staff informed us of the changes implemented in the department as a result of COVID-19. The department has recently created ten cubicles in the majors area with dedicated hand washing facilities in each cubicle and four cubicles in the resus area, again with dedicated hand washing facilities in each cubicle. We were told that Personal Protective Equipment (PPE)[1] is also placed outside each individual cubicle area. We were informed that there were two dedicated waiting areas, a red waiting area for those patients who were confirmed cases of COVID-19 or symptomatic, and a green waiting area for those who tested negative for COVID-19 or were non-symptomatic.

We were told that all staff in the department had undergone training in relation to 'donning and doffing'[2] the relevant PPE. This training has now become part of the mandatory training process along with Infection Prevention and Control (IPC) training.

Even though staff have tried to maintain social distancing whenever possible, they informed us that this is often difficult in busy periods.

We were told that COVID-19 screening would be undertaken on arrival of the patient to the department. A temperature check and COVID-19 swabs would be taken and patients would be signposted to the relevant red or green waiting areas dependent on results and symptoms. We saw evidence of the screening questions that would be asked.

We were also provided with information around the systems in place to ensure IPC measures are effective and up to date in accordance with national COVID-19 policy requirements.

We were told that staff are required to undertake a lateral flow test (LFT)[3] twice weekly and report positive results to senior staff at their earliest opportunity.

We saw evidence of monthly hand hygiene audits which were undertaken November 2021 to March 2022, which showed 100% compliance in the department.

The following areas for improvement were identified:

We were provided with evidence of an IPC audit which was undertaken in September 2021. This identified immediate improvements were needed in order to achieve a satisfactory status.

---

[1] PPE- clothing and equipment that is worn or used in order to provide protection against hazardous substances or environments.
[2] The term "donning and doffing" is used to refer to the practice of putting on (donning) and taking off (doffing) protective gear, clothing, and uniforms
[3] Lateral flow is an established technology, adapted to detect proteins (antigens) that are present when a person has COVID-19.

The audit documentation noted that the cleaning responsibility framework and cleaning frequencies were not clearly displayed in the department and there was no evidence to confirm compliance.

The generic environment, clinical room, resus equipment, oxygen/suction equipment, manual handling equipment, dirty utility, and ward kitchen was found to be dusty and/or soiled.

The audit documentation noted the sanitary fixtures in the bathroom environment were not in a good state of repair. The audit further identified that clinical rooms and store had some single use equipment being put back into drawers.

Clean linen was being stored on top of the cleaning trolley. Further information from the audit identified that there was inappropriate disposal of waste and sharps. It is recommended that the health board ensure a further IPC audit is undertaken and an action plan is completed in order to improve the IPC status in the department.

We saw further evidence that compliance with mandatory training for IPC Level 1 in nursing staff was below 75% with medical staff compliance falling under 45%. Overall compliance with this training within the whole department fell below the standard expected with only 77% compliance.

It is recommended that the health board ensures that all staff undertake this mandatory training within the department.

Safe Care

As part of this standard, HIW questioned the service representatives about how, in the light of the impact of COVID-19, they have adapted their service. We explored whether management arrangements ensure that there are sufficient numbers of appropriately trained staff on the ward to provide safe and effective care.

The key documents we reviewed included:

- Description/Mapping out of the department, including the number of beds and staffing ratios for each area of the ED
- Management structure
- Current staff vacancies (listed by band)
- Current staff sickness (listed by band)
- Escalation policy
- Number of safeguarding referrals - last 3 months

- Last four Make it Safe Reviews (specific to vulnerable patients in the Emergency Department)
- Discharge checklist
- Discharge process/pathway
- Audits in relation to RCEM
- Policy/ Process in relation to the management of patients who are intoxicated/ substance use
- Missing Persons Policy/Process
- Mental Capacity Policy/Process
- Example Observation chart
- Information on CAMHS and ED work
- 20 sets of Emergency Department records from the previous 3 months.

The following positive evidence was received:

We saw evidence of a complete current staff vacancy list and a list of all current staff sickness.

Staff told us that sickness absence always creates issues in staffing, but more so since the pandemic, with many staff having to isolate at different periods. All vacant shifts go out to bank and regular agency staff who have been trained to work in this department, and how to use Symphony[4].

Staff told us they have regular agency workers who fill vacant shifts and these staff know the department well and have access to the digital systems in advance of their shift.

We were told that in addition to the training available through the internal training system, senior staff are aiming to deliver training on different subjects on a weekly basis. There is an intention to have a dedicated study day every six weeks moving forward.

As part of our quality check, we asked staff a number of questions around patient flow. We were told that all admissions are recorded on the WPAS[5] system but this is going to be moved shortly to the Symphony system. WPAS is live and can track a patient's journey through the hospital. Staff informed us they aim to get all patients triaged quickly, however, this isn't always possible, particularly during busy periods.

There is a dedicated triage nurse on shift in the department who is responsible for managing triage. Staff told us that triage can get busy at certain times of the day and sometimes it is necessary to provide an additional triage nurse.

---

[4] Symphony is the clinical system for urgent and emergency care, supporting patient management, tracking and clinical workflow
[5] Welsh Patient Administration System (WPAS)
The Welsh Patient Administration System (WPAS) holds patient ID details, outpatient appointments, letters, and notes.

We asked staff about the identification and management of any vulnerable patients within the department, including children, patients with learning disabilities, dementia or mental ill-health, palliative care patients and patients with substance or alcohol addictions.

We were told that the department has good communication with nurses specialising in all these groups and if someone came in with complex needs, they would contact the relevant nurse lead to ensure prompt review of the patient and to seek advice on managing the patient in the most appropriate way.

In the event patients are waiting for long periods of time in either the waiting area or main department, staff reported that they have regular help and input from the Red Cross volunteers who assist in ensuring the food trolley also goes round both areas three times a day to provide food and drink for patients.

We were informed medical leaders within the department were effective and supportive in their management of junior doctors. They had worked hard to ensure a culture of learning for staff and support them in their roles. Assessment and treatment from doctors were documented clearly and robustly in most of the 20 cases we checked. The medical plans of care and management advice was evidence based in most cases.

We were informed medical leaders supported junior doctors in their development and learning and ensured protected time for training. They had also made efforts to engage with other departments across the health board to foster learning and collaborative working.

The following areas for improvement were identified:

We reviewed the discharge policy and concluded it was not sufficiently specific to ensure safe discharge of patients from the emergency department. During the quality check call, staff also confirmed that there is currently no internal discharge process in place to help staff discharge patients safely. There was a checklist available for staff to complete. However, through reviewing records and speaking to senior staff we ascertained this was not used consistently.

HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of, and are trained in this process, to ensure the safe discharge of patients from this department.

In all 14 records reviewed where the patient was discharged, none contained a completed copy of the department's discharge checklist. In three out of four cases where a patient left against medical advice, the discharge against medical advice form was either not fully completed or absent. In 12 out of 14 cases there was no information recorded by nursing staff relating to the discharge arrangements, checks and safety netting.

This improvement was raised as an issue requiring immediate assurance from the health board.

Arrangements for tracking and monitoring where patients were located within the department were not robust. Records routinely lacked information on where the patient was accommodated. We saw several examples where patient locations were not kept up to date. This had led to confusion and delays in vital care and treatment being provided to patients. Examples included patients who were unwell being placed in the waiting room and staff not being aware they were waiting. In other cases we found that patients had left the department without being seen and were not noted as having left for a number of hours. This exposed patients to risk of harm.

This improvement was raised as an issue requiring immediate assurance from the health board.

Systems for flagging at risk and vulnerable patients were not adequate and meant that staff were not always able to identify where high risk patients were located within the department. This included patients with mental health issues and those at risk of falls.

Through reviews of patient records we identified cases where patients who were vulnerable were placed in areas where they could leave, unseen. In some cases this had occurred and staff were not aware of the absence for long periods. These cases included patients with significant mental health issues and children.

Staff were routinely unaware of the cohort of patients waiting in the waiting room. There was little oversight of this area and patients were not subject to routine or ad hoc checks of their condition and welfare.

This improvement was raised as an issue requiring immediate assurance from the health board.

As part of our quality check, we also asked staff a number of questions around patient flow. We were informed by staff that when they escalated the acuity/status of the department this was not always acted on or was overlooked, as it is regularly noted that the department runs on reduced bed capacity.

The health board should ensure that proactive action is commenced when the bed status/acuity of the department is being escalated.

We were informed by staff that there can be lengthy delays in patients being seen by ED doctors and specialty doctors. Staff told us that communication around this could also be problematic.

The length of time taken for a patient to be reviewed by a doctor was excessive in most cases. This exceeded the time suggested by the assigned triage category in most cases reviewed. In some cases this delay was significant, including in one case where a patient should have been seen within 10 minutes and waited over six hours to see a doctor. This patient subsequently became more unwell. In 14 out of 20 cases, patients were not seen within the recommended time for their triage category.

The health board should ensure that proactive action is commenced when a patient requires urgent assessment by a doctor. This improvement was raised as an issue requiring immediate assurance from the health board.

We were further informed by staff that patients requiring specialty review often encountered delays in being seen by specialty clinicians. For some cases we reviewed the wait was more than 12 hours. The health board should ensure that there is an appropriate pathway of escalation if a patient is not seen within a reasonable timescale by a specialty clinician.

We saw evidence of the observation documentation used within the department. We also saw evidence from a review of clinical records of inconsistencies in recording of physiological observations and NEWS[6] scoring.

In 15 out of 16 cases where physiological observations were indicated, they were not undertaken at a frequency to identify changes or deterioration in the patient's condition and allow for early identification of deterioration. In some of these cases, observations showed a deterioration when rechecked after a significant period of time. This posed a risk that patients could deteriorate unnoticed and not receive time critical interventions.

In some cases observations were not repeated before the patient left the department. This meant there was no accurate record of their clinical condition prior to leaving.

This improvement was raised as an issue requiring immediate assurance from the health board.

We identified that there is a lack of documentation to evidence that there were sufficient processes and arrangements in place to monitor and observe patients presenting with mental health issues.

We observed that there was no consideration given to the high risk nature of these patients and the very specific risks associated with their presentation. This included patients who presented with suicidal ideations and attempts being placed in areas which were not visible to staff.

---

[6] NHS Early Warning Score (NEWS) tool is a scoring system used to alert clinicians to signs of deteriorating health in an adult patient.

In some cases these patients left the department unnoticed and in some cases no attempts were made to locate the patient. Risk assessments and tools for the assessments of patients presenting with mental health conditions were not routinely used.

Arrangements for assessing which patients may require one to one support were also insufficient and inconsistent. This presented a risk to patient safety. This improvement was raised as an issue requiring immediate assurance from the health board.

Evidence based pathways, risk assessments and guidelines were not being used consistently. Examples of guidelines not being used included those issued by NICE[7], RCEM[8] and RCS[9]. This posed a risk to patient safety. In all cases reviewed, standard risk assessments were either not completed fully or absent. These included risk assessments on self harm and suicide, falls risk and pressure damage.

HIW is not assured that there are sufficient risk assessment processes in place to protect patients from avoidable harm. This improvement was raised as an issue requiring immediate assurance from the health board.

In one case it was deemed that a patient who had presented with a potentially lethal overdose of paracetamol was not managed effectively in the department. Our peer reviewer noted that blood results were not documented (paracetamol level, liver function tests and INR[10]) and the clinical peer reviewer was unable to determine if the medical assessment was reasonable. The documentation lacked any detail of the patient's mental capacity or mental state. The patient discharged themselves against medical advice and the form to facilitate this discharge was not completed fully. This was not in line with local or national guidelines. Furthermore, there was no evidence that a paracetamol leaflet was provided as follow up advice.

Important aspects of investigation and checks of patient conditions were either not undertaken or not documented in most cases. This included a patient presenting with a very high heart rate and staff not undertaking an important investigation to check their heart (ECG). In another case a patient presented with abnormal blood test results and these were not noted or actioned by the department.

Patient mental capacity was not considered or documented in 13 of 20 cases reviewed. In these records there was no record of findings that suggested that the patient may lack capacity or that a mental capacity assessment has been carried out in line with RCEM and MCA guidance.

---

[7] The National Institute for Health and Care Excellence (NICE) is the independent organisation responsible for providing national guidance and advice on promoting good health and preventing and treating ill health.
[8] RCEM- The Royal College of Emergency Medicine. The College is established to advance education and research in Emergency Medicine
[9] The royal college of surgeons- A Professional Body Working To Advance Surgical Practice & Patient Care
[10] An INR (**international normalized ratio**) is a type of calculation based on PT test results. Prothrombin is a protein made by the liver. It is one of several substances known as clotting (coagulation) factors.

None of the 20 cases were assessed under the Mental Health Act. This was further evidenced in the RCEM audit undertaken 2019/20 'Assessing Cognitive Impairment in older people'. The audit identified that in 131 eligible patients only 1 had been considered for cognitive assessment.

Safeguarding arrangements were not robust and documentation for the assessment of safeguarding risks was not routinely considered. Safeguarding checklists and prompts were not completed in 18 out of 20 cases.

This improvement was raised as an issue requiring immediate assurance from the health board.

The risk of sepsis was not routinely considered and despite the department having sepsis screening tools, these were not utilised in any cases we reviewed. In some cases, patients showed significant signs of infection and possible sepsis, and in all cases they were not screened or treated in line with the health board's or national guidelines on the assessment and management of sepsis.

Further evidence was provided in the form of Severe Sepsis and Septic Shock 2016/17 audit, which identified that the department fell below the national standard that states that Respiratory Rate, Oxygen Saturations (SaO2), Supplemental Oxygen Requirement, Temperature, Blood Pressure, Heart Rate, Level of Consciousness (AVPU or GCS) and Capillary Blood Glucose should be recorded on arrival. This posed a risk that patients may not receive time critical interventions when required.

This improvement was raised as an issue requiring immediate assurance from the health board.

The management of patients presenting with possible or confirmed alcohol withdrawal was not in line with health board policy or national guidelines. The issues predominantly related to the assessment and monitoring of this group of patients by nursing staff. The Clinical Institute Withdrawal Assessment (CIWA)[11] scoring was not routinely undertaken or monitored. Observation of these patients while waiting to see a doctor did not meet the required standards in all cases reviewed. This included lack of scoring, lack of documented observation and lack of escalation. This posed a risk, as this group of patients have the potential to become very unwell, quickly.

This improvement was raised as an issue requiring immediate assurance from the health board.

---

[11] The Clinical Institute Withdrawal Assessment Alcohol Scale Revised (CIWA-AR) is an instrument used by medical professionals to assess and diagnose the severity of alcohol withdrawal.

Patients presenting with mental health issues and self harm were not routinely assessed for their risk of further harm. This had resulted in several patients leaving the department without being seen and in some cases returning after further self harming.

HIW was not assured that staff were recording and documenting the care and treatment they provide. This was further illustrated by evidence provided of RCEM Mental Health (self-harm) QIP 2019/20 audit, which identified that improvements should be undertaken in relation to close observations of patients in the department who are deemed medium or high risk of suicide. In addition a clinician reviewing a patient presenting with self-harm or a primary mental health problem, should have a recorded brief risk assessment of suicide or further self-harm. There should also be written evidence that patients have had an assessment for cognitive impairment during their visit to the department using a validated nationally or locally developed tool.

This improvement was raised as an issue requiring immediate assurance from the health board.

In all cases reviewed, the standard of nursing documentation fell far below the expected standard and did not include significant information required. This included the complete absence of documentation in some instances. This was despite some patients being present in the department for in excess of eight hours and requiring nursing care.

The documentation in all cases was missing important information and assessments. This included documentation of checks and monitoring, risk assessment, general condition updates, communication and specific needs such as food and drink.

This improvement was raised as an issue requiring immediate assurance from the health board.

In one instance it was evident from the records review that there was a failure to provide complete records and recognise unscheduled re-attendance requiring Consultant Sign-Off in line with June 2016 - RCEM - Quality in Emergency Care Committee Standard. We saw further evidence of this in the RCEM audits provided which was undertaken in 2016/17, this audit identified that only 14% of patients were identified as reviewed by consultants under this standard. Further to this, there was one instance from the records review that also identified a patient who was brought into the department in police custody was not assessed in line with RCEM Best Practice Guideline - Emergency Department Patients in Police Custody - June 2016 and was discharged at triage.

Governance & Staffing

HIW was not assured that there was a supportive culture which promoted accountability and safe patient care. We found that senior nursing staff had raised concerns with middle management and these concerns had not been acted on. Senior staff told us that they were

aware of a number of the issues identified but could not tell us what they had done to remedy these and safeguard patients.

We were told by staff that senior operational and nursing leadership was inconsistent and did not always support the staff within the department to deliver safe and effective care.

This improvement was raised as an issue requiring immediate assurance from the health board.

We found that the culture within the department lacked accountability and did not encourage nursing staff to deliver evidence based, safe care. The department was routinely operating at a high level of escalation. We found that due to this, staff were not always escalating their concerns, or reporting patient safety issues and incidents. This meant key lessons were not always learned and posed a risk of reoccurrence.

This improvement was raised as an issue requiring immediate assurance from the health board.

It was accepted by managers that the department operated at a very high occupancy /acuity level. As a result staff within the ED and senior leaders were not following the health board escalation policy fully. This led to the approach to managing patient flow becoming sometimes chaotic and ineffective at all levels.

This improvement was raised as an issue requiring immediate assurance from the health board.

Medical staff appeared to be well supported and did attempt to hold staff to account. The medical leadership within the department was effective and supportive for junior doctors. However, we found that due to the deficits in the nursing care, documentation and escalated nature of the department this presented significant barriers to medical staff being able to undertake their roles effectively.

This improvement was raised as an issue requiring immediate assurance from the health board.

We found that there had been an unstable senior nursing leadership situation for a number of months in the more senior lines of leadership and management. This had resulted in several interim positions and a feeling of instability and change fatigue within the department and management structure. Leaders within the department were not aware of some of the issues identified, and where they were aware, had not recognised the gravity and seriousness of the issues.

Leaders for the department had attempted to raise concerns about several issues of patient safety. However, these had not been listened to or acted on. Leaders acknowledged that

significant cultural change was required to make the department a safe and effective environment for patients and staff.

This improvement was raised as an issue requiring immediate assurance from the health board.

The management of incident investigations was not robust and failed to identify key safety issues and ensure robust remedial action was taken. This meant that patients were exposed to risk of harm. In one example we found that key issues around patient triage had not been identified and addressed.

This improvement was raised as an issue requiring immediate assurance from the health board.

We found that repeated issues were present in several of the make it safe reviews we reviewed. This included lack of risk assessment, lack of observations and poor documentation. Despite these issues persisting throughout several incidents over a period of months, senior staff could not tell us what had been done to escalate these risks and address them at a senior level.

This improvement was raised as an issue requiring immediate assurance from the health board.

We were told by staff that learning from incidents is not something which is regularly shared across Betsi Cadwaladr University Health Board hospital sites. The health board should ensure that there are robust mechanisms in place to share learning from incidents.

This improvement was raised as an issue requiring immediate assurance from the health board.

What next?

Where we have identified areas for improvements during our quality check and require the service to tell us about the actions taken to address these, an improvement plan providing details will be provided at the end of this quality check summary.

Where an improvement plan is required, it should:

- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the areas for improvements identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the quality check.

As a result of the findings from this quality check, the service should:

- Ensure that the areas for improvements are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

If no areas for improvement were identified during this quality check, an improvement plan will not be required, and only the quality check summary report will be published on HIW's website.

Immediate improvement plan

Service: Ysbyty Glan Clwyd

Area: Emergency Department

Date of Inspection: 8th – 10th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale

Healthcare Inspectorate Wales (HIW) undertook an announced remote quality check of the Emergency Department at Ysbyty Glan Clwyd from 8th -10th March 2022. A clinical review of 16 case records was undertaken and the following immediate assurances were found.

HIW is not assured that the current arrangements for discharging vulnerable patients from the emergency department are safe and robust, to prevent risk of harm.

- Increasingly staff working within the emergency department are discharging patients with complex and varied needs. We observed this through our review of records and through staff dialogue. Therefore, it is of utmost importance that staff working within the department consider all aspects of discharge to ensure patients are safe when leaving the department
- Within our review of records we found several records which indicated that discharges were not being undertaken consistently, and basic checks were not documented as being undertaken in all cases. These checks included making sure vulnerable patients had access to their property and were haemodynamically stable prior to discharge
- There were significant gaps in the documentation of discharge arrangements. This meant in some cases it was not possible to identify what happened to the patient or where they went
- In all 14 records reviewed where the patient was discharged, none contained a completed copy of the departments discharge checklist

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
- In three out of four cases where a patient left against medical advice, the discharge against medical advice form was either not fully completed or absent - In 12 out of 14 cases there was no information recorded by nursing staff relating to the discharge arrangements, checks and safety netting - In one case, although there were some notes on discharge, these were not sufficient and did not take account of all factors to facilitate a safe and effective discharge, placing patients at significant risk of harm. **HIW is not assured that the arrangements for monitoring, observing and tracking patients throughout the department are sufficient to protect patients from avoidable harm.** **Waiting areas** - The arrangements for monitoring patients within the adult waiting areas were insufficient and meant patients were placed at risk of avoidable harm. Patients with 'major' presentations (patients who would require a trolley in the Majors area if available) were routinely accommodated in the waiting room while waiting to be seen. These patients were not subject to any consistent or ongoing checks or monitoring of their condition, potentially leading to deterioration of their condition by the time they were seen by a doctor. This included patients with infections, mental health problems and significant head injuries - In one significant case a patient was placed in the waiting room with a suspected bowel perforation. They were later transferred to intensive care and sadly died the waiting room is not a suitable placement for a patient who has the potential to deteriorate rapidly and catastrophically. - The lack of oversight of the waiting area meant that high risk patients were able to leave the waiting area unnoticed. In several cases their absence was not noted until many hours later, at which point the patient may have been exposed to significant risk. Examples included a child who had attempted suicide, patients who had attempted self-harm and suicide, and patients who had signs of alcohol withdrawal and abnormal physiological observations - In some cases observations were not repeated before the patient left the department. This meant there was no accurate record of their clinical condition prior to leaving - There were no clear lines of accountability and responsibility for the waiting areas, with arrangements for checking the area adhoc and inadequate - In 14 out of 16 cases, patients were not seen within the recommended time for their triage category.				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale

• The length of time to review by a doctor was excessive in most cases. This exceeded the time suggested by the assigned triage category. In some cases this delay was significant including in one case where a patient should have been seen within 10 minutes and waited over six hours to see a doctor. This patient subsequently became critically ill
• There were insufficient processes and arrangements to monitor and observe patients presenting with mental health issues. We observed that there was no consideration given to the high risk nature of these patients and the very specific risks associated with their presentation
• Arrangements for assessing which patients may require one to one support were insufficient and inconsistent.
 	
All areas of the department
• Physiological observations and visual checks of patients throughout the department were not undertaken consistently or at a frequency to enable effective identification of deterioration or changes to a patient's condition and we found an inconsistent approach to the monitoring and recording of observations and early warning scores
• In 15 out of 16 cases where physiological observations were indicated, they were not undertaken at a frequency to identify changes or deterioration in the patient's condition:
   o In one example a patient who had suffered a seizure and head injury had infrequent observations and did not include neurological parameters
   o In one example a patient presented with a significantly raised pulse rate following suspected substance misuse. This parameter was not checked for a number of hours, which is not in line with RCEM guidelines on the observations taking
   o In another case a patient was noted to be critically ill and requiring urgent surgery. This patient had significant hypotension, but despite this, there is no record of their observations being repeated for a number of hours
• Arrangements for tracking and monitoring where patients were located within the department were not robust. Records routinely lacked information as to where the patient was accommodated. We also saw several examples where patient locations were not kept up to date. This had led to confusion and delays in vital care and treatment being provided. In one case it appears to have led to a significant delay in a patient receiving surgical review. The patient sadly continued to deteriorate during the time they were not able to be located, and later required surgery and died
• Systems for flagging at risk and vulnerable patients were not adequate and meant that staff were not always able to identify where high risk patients were. This included patients with mental health issues and falls risks				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale

• Despite the department having a system for intentional rounding, this was not routinely undertaken or documented. This included patient groups who may have been at higher risk of developing pressure damage. Consistent rounding or checks were not evident in any of the cases reviewed.
• Evidence based pathways and guidelines were not being used consistently. Examples of guidelines not being used included those issued by NICE, RCEM and RCS. This posed a significant risk to patient safety:
    ○ This included an example where a patient had suffered a head injury with a loss of consciousness. This patient had no documented checks or observations for a six hour period after presentation. This is not in line with guidance from RCEM or NICE on the management of head injuries.
 	
HIW is not assured that sufficient risk assessment processes are in place to protect patients from avoidable harm.
• In all 16 reviewed cases, core and relevant risk assessments were absent or incomplete. This included risk assessments on falls, pressure area damage and bed rails. This meant that staff were potentially unsighted on the individual risks for each patient and therefore these risks may not have been mitigated
• Safeguarding checklists and prompts were not completed in 15 out of 16 cases. This included the domestic violence checklist for adults and the safeguarding children's checklist:
    ○ In one case a child had presented with issues which would have prompted a safeguarding referral. Despite this the safeguarding checklist was not completed. A referral to the hospital liaison nurse was completed later, however, no efforts were made to safeguard the child in the immediate term. No contact was made with social services for advice or guidance. This was despite the child self-harming, appearing withdrawn and going missing from the department
• We saw that in some cases the absence of risk assessment and associated mitigations had potentially led to patients suffering harm. In one case a patient attended with a cerebral bleed following a fall. Despite this, no falls risk assessment was completed. The patient suffered two falls and sustained further injuries while in the department
• In another case a patient presented with seizures. Despite this there were no risk assessments present for any risks including bed rails and falls. The patient was subsequently found on the floor following a seizure and sustained further injuries
• Despite the department implementing a safety checklist for all patients, this was consistently missing or not completed. This meant key aspects of patient safety were not considered, identified or managed.
• Patient risk of pressure damage was routinely not assessed in the cases we reviewed				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
• We were not assured that risk of sepsis was routinely considered. Despite the department having sepsis screening tools these were not utilised. In some cases patients showed significant signs of infection and possible sepsis and were not screened or treated in line with the health board's, or national, guidelines • The management of patients presenting with alcohol withdrawal was not in line with the health board policy and national guidelines. The issues predominantly related to the assessment and monitoring of this group of patients by nursing staff. Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scoring was not routinely undertaken or monitored and observation of these patients while waiting to see a doctor was inadequate in all cases reviewed. This posed a significant risk as this group of patients have the potential to become very unwell quickly • Patients presenting with mental health issues and having self-harmed were not routinely assessed for their risk of further harm. This had resulted in several patients leaving the department without being seen and in some cases returning after further self-harming. **HIW is not assured that nursing staff are adequately recording and documenting the care and treatment they provide. This poses a significant risk to patient safety.** • In all cases reviewed the standard of documentation fell far below the expected standard and did not include significant information required. Record keeping was consistently poor and lacked significant detail • In 13 out of 16 cases reviewed this include lack of any nursing documentation. This meant it was unclear from the documentation whether the patient had received any nursing care or input • Key areas which were routinely not completed included risk assessments, documentation of care provided, checks and observations and mental capacity assessments • In seven out of nine cases where the patient presented with a history which could indicate dysfunction of the mind, no mental capacity assessment was documented for key decisions. This included patients deciding to leave the department against medical advice • In the other two cases capacity was documented, but did not meet the standard for documentation of this in line with national standards. **HIW was not assured that there is a supportive culture which promoted accountability and safe patient care. Senior operational and nursing leadership was inconsistent and did not always support the staff within the department to deliver safe and effective care.**				

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
- We found a culture in the department which did not encourage staff to deliver evidence based, safe care, with poor accountability for individual actions. - The department was routinely operating at a high level of escalation. We found that due to this, staff were not always escalating their concerns, or reporting patient safety issues and incidents. This meant key lessons were not always learned and posed a risk of reoccurrence - It was accepted that the department operated at a very high occupancy /acuity level. As a result staff within the ED and senior leaders were not following the health board escalation policy. The led to the approach to managing patient flow becoming sometimes chaotic and ineffective at all levels - We found that there had been an unstable senior leadership position for a number of months in the more senior lines of leadership and management. This had resulted in several interim positions and a feeling of instability and change fatigue within the department and management structure - Leaders within the department were not aware of some of the issues identified, and where they were aware, had not recognised the gravity and seriousness of the issues. - Leaders for the department had attempted to raise concerns about several issues of patient safety. However, we were told that these had not been listened to or acted on - Leaders acknowledged that significant cultural change was required to make the department a safe and effective environment for patients and staff - The management of incident investigations was not robust and failed to identify key safety issues and ensure robust remedial action was taken. This meant that patients were exposed to risk of harm. In one example we found that key issues around the patient triage had not been identified and addressed - We found that repeated issues were present in several of the make it safe reviews we reviewed. This included lack of risk assessment, lack of observations and poor documentation. Despite these issues persisting throughout several incidents over a period of months, senior staff could not tell us what had been done to escalate these risks and address them at a senior level.				
HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process,	**Standard 5.1 Timely Access**	Daily spot checks of the ED Discharge Checklist will be undertaken manually for admitted	Head of Nursing and	Immediate and ongoing

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
to ensure the safe discharge of patients from this department. HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department.		and non-admitted patients (until the symphony system is embedded, which will enable the automated pull of the information.) The results from this will be extended to include Minor Injuries Units (MIUs) and will be presented to the HMT on a weekly basis to provide oversight of the discharge process. The ED Leadership has requested (through the BCU wide symphony user group) that the Discharge Checklist is made mandatory for all patients. Currently it is only mandatory for patients where a decision to admit has been made. Symphony goes live at YGC on the 30th March 2022 and we are seeking assurance that this programming change is achievable by this date. It has been agreed by ED leads to include extra fields to the mandatory checklist, including safeguarding prompts, concerns and mental capacity. This will be	Clinical Director Directorate Manager ED ED Leadership team	 30th March 2022 30th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
HIW requires the health board to have an ED specific discharge process in place and ensure all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department.		applied to all admitted and non-admitted patients The BCUHB wide Discharge Policy is being reviewed and will include specific ED discharge elements. The policy will be in place from early May 2022 and a roll out process will be implemented with ED staff.	Deputy Chief Executive and Executive Director of Nursing and Midwifery, and Assistant Director of Central Area	Early May 2022
		Whilst awaiting the updated Discharge Policy, all EDs have been instructed to use the BCU wide discharge checklist, and the applicability of the MIUs is being assessed	Deputy Chief Executive and Executive Director of Nursing and Midwifery	Immediate
HIW requires the health board to have an ED specific discharge process in place and ensure		Professional accountability is being reinforced via the ED leadership, supported by the HMT (who will personally undertake random spot	Head of Nursing / Clinical Director and HMT	Immediate

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
all staff are aware of and trained in this process, to ensure the safe discharge of patients from this department.		checks) in relation to the responsibility and accountability when discharging patients from ED by strengthening processes, improving oversight and introducing spot checks, further training and reinforcing professional expectations.

Educational sessions regarding professional regulation and record keeping have already commenced for all registered nursing staff. The importance of quality checks will feature within this, including safeguarding, pressure ulcers, falls and identification of infection risk and sepsis. This will be extended to all clinical and support staff.

Prior to the next version of the rota, we will ensure an experienced Band 6 is available to lead on all shifts 24/7, if there is not a Band 7 not already rostered.

A band 7 senior leadership meeting has been undertaken (16th March | Head of Nursing / AHP Lead / Clinical Director

Head of Nursing / Matron

Head of Nursing / Matron | Commenced 10th March, due for completion by 24th April 2022 in YGC

16th March 2022

8th May 2022 |

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		2022) to feedback the key findings from the HIW report. It has been agreed that there will be a band 7 on duty 24/7 to ensure senior oversight of the department. This will take effect from the next version of the rota, which is from 8th May. ED Safety Huddles will be undertaken every 2 hours to provide oversight of any patient safety, quality, experience and concerns, and the safety of the department. Key areas will include managing a deteriorating patient, as well as managing associated risk. An SOP describing this approach (incorporating the roles and responsibilities of the HMT, the senior doctor and nurse on duty at every shift) in order to manage whole site and system risk will be rolled out for implementation by 25th March 2022.	Head of Nursing / Matron HMT Head of Nursing/ Head	16th March 2022 25th March 2022 22nd March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		A series of steps have been agreed around roles and responsibilities that will enhance oversight of patient safety and quality, whilst ensuring that the ED nurse in charge can be entirely focused on patient safety quality and experience. These steps are commencing on the 22nd March and include: i) A further CSM based within the EQ throughout the daytime ii) Move from EQ based huddles to ED safety huddles with a defined SOP on the key areas of focus iii) The flow responsibilities that currently sit within the Nurse in charge role will move to an ED Clinical Flow co-ordinator. Volunteers will be requested to focus on ensuring patients are offered food and drinks and that contact with families/friends and	of Site / Directorate Manager / Matron Head of Nursing/ Head of Site / Directorate Manager / Matron	 25th March 2022 1st April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		carers can be maintained, escalating as appropriate Discharge planning will commence from the point of arrival. All patients of any age or with any type of vulnerability to be raised at ED safety huddle prior to discharge, to ensure that relevant risk assessments have been undertaken.	Head of Nursing/ Head of Site / Directorate Manager / Matron	
HIW requires details of how the health board will ensure that all staff are aware of their duty to maintain accurate, up-to-date, complete and contemporaneous records at all times.	**Standard 3.5 Record Keeping**	Educational sessions regarding professional regulation and record keeping have commenced for registered nurses and support staff, and will be rolled out to include medical and AHPs. This will be augmented by clinical audit support from corporate teams, which will be part of a broader cycle of audits undertaken. This will also include the implementation of CIWA guidelines The HIW report has been shared with the senior nursing and medical	Head of Nursing / Clinical Director / ED Practice Development Nurse / Corporate Education Team Clinical Director / ED	Commenced 10th March 2022/ ongoing Commenced 16th March

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		teams. A daily spot check of record keeping will be undertaken (incorporating input from HMT) and findings reported to the governance meeting	Matron / ED Nurse in Charge	2022/ ongoing
		The BCU Clinical Executive Directors have indicated to all clinicians the importance of the professional standards, in relation to maintaining appropriate and comprehensive reports.	Clinical Executive Directors	Commenced 17th March 2022
		Following acceptance of this improvement plan by HIW, the report will be shared across the site and the importance of the findings. Once the report has been submitted and approved this will be formally shared through site PSQ, the Clinical Director Forum and other forms. Learning will also be shared across sites through the North Wales Emergency Care Forum.	HMT	Commenced1 0th March 2022
		We have commenced NMC record keeping and accountability training sessions specifically for ED staff. This is being led by Associate Director of Professional Regulation and Education.	Associate Director of Professional Regulation and Education	End of April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		We are undertaking a review of PADR compliance, preceptorship arrangement for new qualified staff and induction programmes for all registered and support staff (medical and nursing). This will inform any gaps in knowledge and will include contemporary record keeping standards. General training has already commenced. In order to address any gaps in knowledge around record keeping we will implement a tailored training plan based on individual needs.	Head of Nursing/ Clinical Director	25th March 2022
		All registrants will be issued a formal notification with regard to their roles and responsibilities as a registrant. The letter will contain their job description, NMC/GMC code of Professional Conduct and how to mitigate or escalate any actual or potential concerns whilst on shift and beyond. Staff side and HR engagement is already underway with agreement in place.	Clinical Director / Head of Nursing / AHP Lead / Chief Pharmacist	25th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
HIW requires details of how the health board will ensure that there are measures in place to ensure patients accommodated in all areas of the department, including the waiting room, are observed and monitored to ensure their safety.	**Standard 2.1** Managing Risk and Promoting Health and Safety	In order to enhance the current Manchester triage review arrangements, the nurse in charge will ensure that a dynamic risk assessment of the waiting areas, including ambulances will take place every 30 minutes.	ED Nurse in Charge	25th March 2022
HIW requires details of how the health board will ensure that there are measures in place to ensure risks to patient safety are assessed and mitigated.		The nurse in charge will redeploy additional staff when required to mitigate any risks. An SOP is being developed to outline the roles and responsibilities of the registered nurses and HCAs that are accountable for the waiting areas on a shift by shift basis – and this will be in place by 25th March 2022	ED Nurse In Charge and Clinical Flow coordinator	25th March 2022
The health board must provide HIW with details of the action to be taken to ensure consistent monitoring and recording of visual observations, physiological observations and NEWS scoring for all patients.		Reinforcement of Intentional rounding and clinical observations processes will be reflected in the safety huddles and escalated to the nurse in charge where indicated.	ED Nurse In Charge	25th March 2022
		This will be validated on a daily basis and the results reported to HMT on a weekly basis.	Head of Nursing / ED Matron /	25th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
			Matron of the Day	
		HMT to implement Health Board workforce recommendations, ensuring refresh of plans in line with professional standards, ensuring all gaps are in the process of being recruited to.	HMT	Immediate
		Roster compliance will be strengthened to ensure compliance with KPIs. This will be validated for approval by the HoN and Clinical Lead prior to every roster sign off.	Head of Nursing and ED Matron	23rd March 2022
		In addition to the above, real-time staffing levels for the ED are monitored via the Safe Care systems twice daily meeting between the matron of the day and the HoN. Any actual or potential issues are mitigated/escalated via staff movement or bank or agency, or escalated to HMT/silver or gold out of hours	Head of Nursing and ED Matron	23rd March 2022
		Nurse in charge and Clinical Flow Coordinator to ensure that all patients in ED are accounted for at all times. A roll call will take place	Head of Nursing /	15th April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		before every 2 hourly safety huddle and any concerns escalated. Spot checks of the safety huddles will take place to ensure compliance with process. If a patient leaves without being seen, there are clear posters in place stating that they must make the receptionist aware. Where this happens, this will be escalated to the nurse in charge immediately.	Directorate General Manager	
		Safeguarding team are providing training on the process of identifying vulnerable patients/children in ED. This process will also be cross – referenced in the Discharge Policy, which will also include the management of vulnerable patients.	Safeguarding Deputy Chief Executive/ Executive Director of Nursing	Early May 2022
		All staff have been reminded of their professional responsibilities to escalate concerns. HMT and ED leadership will increase their visibility in clinical areas by undertaking the safety huddles, and undertaking walkabouts, particularly in times of high escalation	HMT	30th March 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		This will be underpinned by an escalation plan to be devised that outlines what key actions need to take place as the acuity and volume in the department increases.	Head of Nursing / ED Matron	30th April 2022
		All band 5 and band 6 Registrants will undertake the RCN Emergency Nurse management competencies which include taking observations and how to escalate and manage risks where appropriate	ED Matron	September 2022
		A gap analysis will be undertaken with regard to band 6 and 7 clinical and leadership skills that will lead to generic and bespoke training to meet the clinical and leadership requirements of their roles.	Head of Nursing / Clinical Director	End of April 2022
		KPIs will be set for all roles	Head of Nursing	End of April 2022
		A Foundation for Emergency Nursing Course will be implemented on a rolling basis to include all band 5 RN's.	Head of Nursing	End of April 2022
		Emergency Department Discharge checklist to be amended so that all patients receive a final set of	Head of Nursing /	End of April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		observations prior to transfer out of the department and discharge. This will be aligned with the BCU discharge policy and compliance spot checked on a daily basis and reported to HMT on a weekly basis.	Clinical Director	
		Clear identification of Nurse in Charge will be in place by the end of April 2022	Head of Nursing	End of April 2022
The health board must provide HIW with details of how it will ensure that there are robust and appropriate leadership arrangements in place with robust and effective governance processes and measures.

HIW requires assurance from the health board that our findings are not indicative of a systemic failure to provide safe, effective and dignified care across all services.

The health board must provide HIW with details of the action to be taken to ensure that, at all times, staffing levels are appropriate in order to meet the needs of patients on the ED. | **Governance and Leadership**

Standard 7.1 Workforce | The Health Board will put in a place a process enabling the HMT, Executive Team, and Independent Board members a regular process of gaining visibility and accessibility across service and clinical areas, which will incorporate walkabouts, safety huddles, *Ask the Panel events*, as well as hosting monthly listening events for ED staff.

HMT will put in place a process of triangulating information from different sources such as: Incidents, complaints, Speak out safely guardians, risks and monitor this as part of a mechanism to assess effectiveness. | HMT

Executive Team and Independent Board Members

HMT | Commenced for Board visits

30th March 2022 for HMT

30th April 2022

30th April 2022 |

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
The health board must provide HIW with details of the action to be taken to provide on-going support to staff and promote and maintain staff well-being.		As part of regular performance review meetings, there will be corporate oversight of this action plan. This will incorporate assurance reports through to the Patient Quality and Safety Group.	HMT / Executive Team	Implemented
		Interim Head of Nursing in place to ensure cover for long term absence. This role will provide daily Senior visibility and give staff an opportunity to share information and escalate concerns.	HMT	
		Staff wellbeing initiatives are in place and will be promoted, and Speak out Safely Guardians have attended the EQ Governance Meeting on 24th February 2022 and all staff were encouraged to raise issues. Following this we will implement a monthly collaborative forum consisting of HMT, Staff Side and SoS Guardians, where the HMT can be appraised of any emerging issues from the SoS Guardians.	HMT and SoS Guardians	4th April 2022
		Management of rosters will be strengthened to ensure compliance with KPIs. This will be validated for	Head of Nursing / ED Matron /	7th April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		approval by the HoN and Clinical Lead prior to every roster sign off.	DoN / HoN	May 2022
		In addition to the above real-time staffing levels for the ED footprint are monitored via the Safe Care systems twice daily meeting between the matron of the day and the HoN where any actual or potential issues are mitigated via staff movement or bank or agency.	DoN / HoN and Medical Director	May 2022
		Implement a 'QI Thursday' for senior nursing and medical staff to increase visibility, share good practice and undertake assurance visits.	ED leadership team	May 2022
		Safety huddle/debrief post shift, which will include review of shift log and documentation. This will link to existing support around TRIM where required.	ED leadership team	End April 2022
		We will extend the use of LEAF (Learning, Education, Alerts and Feedback) across all staff groups and ensure learning from incidents and concerns is implemented into practice.		End April 2022

Improvement needed	Regulation/ Standard	Service action	Responsible officer	Timescale
		Build in PADR/appraisal/LEAF process e.g. to include the submission of a piece of reflective practice	ED leadership team	
		Bespoke training in Risk Management will be implemented in a prioritised manner, starting with those in key leadership positions in the department across medical, nursing and operational staff. This will focus on 3 key areas risk assessment, risk escalation arrangements and documentation of risk assessments, and will specifically address areas such as seizures, pressure areas, sepsis management, mental health assessments and alcohol withdrawal.	ED leadership team / Interim Board Secretary	End April 2022

Ysbyty Glan Clwyd (Emergency Department) Representative:

Name (print):   Neil Rogers

Role: Acute Site Director

Date: 21 March 2022

Improvement plan

Setting: Ysbyty Glan Clwyd

Ward/Department/Service:
Emergency Department

Date of activity: 8-10th March 2022.

The table below includes improvements identified during the Quality Check, where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Please note, all actions are expected to be complete within three months of the Quality Check and the final version of the Improvement Plan is to be submitted via Objective Connect once complete.

Reference Number	Improvement needed	Standard/ Regulation	Service Action	Responsible Officer	Timescale
1	The health board should ensure that proactive action is commenced when the bed status / acuity of the department is being escalated.	**Standard 2.1** Managing Risk and Promoting Health and Safety	Safety huddles are in place every two hours, 24 hours a day 7 days a week. An electronic log is maintained for all safety huddles. All areas of the Emergency Department are reviewed at the safety huddle, including the waiting room and any ambulances queued outside. A risk matrix is completed defining the overall escalation status of ED at that point and what actions have been taken within ED to control and	Director of Nursing, YGC.	16th May 2022

			mitigate any risks. Sufficient clinical capability will be maintained to ensure all patients are actively triaged and observed regardless of location		
			In between the 2 hourly reviews, senior hourly board rounds will take place.		
			Escalation in-between huddles and board rounds will be from clinicians to the ED Nurse in Charge, then as needed to the Senior Consultant, and Clinical Site Manager/On-Call Manager.		
			When the safety huddle triggers any issues in relation to overall capacity / acuity within the department or excessive volumes or delays in patients awaiting transfer out, the Hospital Management Team (HMT) will be alerted. Out of hours, escalation is via the management on call rota. As a consequence of this consistent approach to escalation, patients at clinical risk of deterioration will receive the appropriate input and be transferred to the appropriate care setting.	Director of Operations, YGC.	16th May 2022
			The ED escalation status feeds through in to the overall hospital site escalation plan, with defined roles and responsibilities and	Director of Operations, YGC.	16th May 2022

			timescales to de-escalate the position in the Emergency Department. The plan is reviewed on a dynamic basis, in accordance with the position at the time and will be a formal agenda item for the weekly HMT meetings.		
2	The health board should ensure that all staff are compliant with mandatory training		Staff will be supported to complete all aspects of available mandatory training that are essential to their role.	Director of Nursing, YGC.	31st July 2022
			Where there have been issues with regard to face to face / classroom sessions due to social distancing constraints, staff will be rostered and freed up to attend now that these restrictions have eased. This will include the immediate organisation of resuscitation training (ILS levels 2 & 3) for those staff who are not compliant and where compliance has lapsed.	Director of Nursing, YGC.	31st July 2022
			Where appropriate, additional training sessions will be convened to take place locally within the Emergency Department to provide bespoke training to drive up compliance levels, including Level 2 and 3 Safeguarding for registrants and Level 1 for all staff.	Director of Nursing, YGC.	31st July 2022
			The Hospital Management Team will track performance to maintain	Acute Care Director, YGC	31st July 2022

			mandatory training compliance levels across the Emergency Department with a trajectory to achieve a minimum 85%. Compliance will be a standing agenda item on the weekly Hospital Management Team (HMT) meeting.		
3	It is recommended that the health board ensure a further IPC audit is undertaken and an action plan is completed in order to improve the IPC status in the department		Further audits were undertaken by the Infection Prevention & Control Team. These reports have been reviewed, immediate actions taken and further actions incorporated into the existing action plan. These will be overseen by the site Quality and Safety meeting.	Director of Nursing, YGC.	Completed - 4th May 2022
			A further audit has been forward-planned for week commencing 20th June 2022. This timescale is on the advice of the Health Board's Director of Nursing for Infection Prevention & Decontamination, to formally review and scrutinise progress.	Director of Nursing, YGC.	20th June 2022
			An environmental improvement plan is being developed jointly with Estates and Facilities, and will be in place to include additional support to maintain IPC standards.	Acute Care Director, YGC.	30th June 2022.
4	The health board should ensure that proactive action is commenced when a patient requires specialty review or if	**Standard 5.1 Timely Access**	The Internal Professional Standards (IPS) have been refreshed and issued to all specialities and will	Acute Care Director, YGC.	16th May 2022

there is a delay in receiving a specialty review.		be shared at all future inductions on an ongoing basis to ensure that expectations are understood and visible.		
		Training sessions will be organised for all specialities to outline IPS requirements and to highlight any gaps in service provision, and that any mitigations required have been put in to place. This will be overseen and monitored by the weekly HMT meeting.	Medical Director, YGC	30th June 2022
		The Hospital Management Team will put an expectation in place, following a workshop with all speciality Clinical Directors and Clinical Leads, that speciality response time to ED will be a maximum of 1 hour at which point it will be escalated.	Acute Care Director, YGC.	23rd May 2022.
		On an hourly basis, a board round will be undertaken in ED, identifying any patients of concern where a speciality review is either outstanding, or where a review is required and has not been made.	Medical Director. YGC	23rd May 2022
		Any patient who is outstanding a speciality review within the 1 hour standard will be highlighted to the ED Nurse in Charge for escalation to the Registrar for the appropriate speciality. Further escalation will be to the Speciality	Medical Director, YGC	23rd May 2022

		Consultant if a response is not received within 30 minutes of escalation.		30th May 2022
		Delivery against the IPS will be monitored for each speciality and reviewed by the HMT weekly, with further action to be taken if the IPS standards have not been delivered.	Acute Care Director, YGC.	

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Name: Neil Rogers, Acute Care Director, Ysbyty Glan Clwyd

Date: 12th May 2022.

Report title:	Quality Achievements		
Report to:	QSE Committee		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	3.6
Executive Summary:	The purpose of this report is to provide the Committee with some of the Health Board's recent awards, achievements and recognitions.		
Recommendations:	The committee is asked to receive this report.		
Executive Lead:	Gaynor Thomason, Interim Executive Director of Nursing and Midwifery		
Report Author:	Matthew Joyes, Associate Director of Quality		

Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☐
Assurance level:	Significant ☒ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

This paper highlights some of the recent quality awards, achievements and recognitions

Link to Strategic Objective(s):	Quality
Regulatory and legal implications	N/A
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	N/A
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	N/A
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	N/A
Reason for submission of report to confidential board (where relevant)	N/A

Next Steps: N/A

List of Appendices: Quality Achievements paper

Betsi Cadwaladr University Health Board
Quality Achievements

Ysbyty Gwynedd Nurse invited to Queen's Garden Party in Honour of her Work

A nurse with more than 40 years of NHS service has been recognised for her hard work and dedication with an invitation to attend a Royal Garden Party at Buckingham Palace. Sonya Edwards began her career in 1979 as a student nurse at St David's School of Nursing and at the C & A Hospital before joining Ysbyty Gwynedd.

She said: "It was an amazing experience and such an honour and a privilege to be invited.

"At first I thought I had been invited by mistake and that the invite I received was a scam! I rang the number on the invite and it took for them to call me back a second time to believe it was real! Sonya, who retired from the nursing profession earlier this year, said she feels lucky to have worked with such dedicated colleagues over the years."

New Gamma Camera at Wrexham Maelor Hospital

Patients will benefit from a quicker and more detailed scanner that is set to be installed at Wrexham Maelor Hospital later this year. The gamma camera is an imaging device which scans parts of the body, including most major organs such as the brain, lungs and bones. The new state-of-the-art camera, which is replacing an old imaging device, has faster scan times, clearer images, and a lower radiation dose, which will overall help speed-up patient diagnosis.

David Jones, Principal Radiographer, for Nuclear Medicine and PET-CT, said: "We have three Nuclear Medicine departments within the Health Board one at each general hospital, and currently the radiology department at Wrexham Maelor Hospital, is having a major upgrade.

The new scanner is part of a multi-million-pound equipment replacement programme that Betsi Cadwaladr University Health Board is carrying out within the Radiology service across North Wales, which includes X-ray rooms, scanners and ultrasound machines.

Betsi Specialist Bereavement Midwives Recognised by Chief Nursing Officer

A group of midwives from the Health Board have received awards for their vital work supporting bereaved parents who suffer pregnancy or baby loss. Specialist bereavement midwives Jan Garrod, Lucy Dobbins and Sarah Griffith are part of the Snowdrop Bereavement Team covering North Wales. Chief Nursing Officer for Wales, Sue Tranka, felt their work warranted individual Excellence Awards to mark their compassionate roles. Each

received a certificate and commemorative badge from Dr Ruth Wyn Williams on International Midwife Day - and some heartfelt words of appreciation from Ms Tranka.

The Snowdrop Bereavement Team help families cope with their emotional loss but crucially provide immediate care, birth planning, memory making and offer support with funeral choices. Vitally it reduces the number of times families have to recount their harrowing stories, because of the continuity of support in dealing with one specialist midwife as they navigate the most difficult of times.

The team has also started a Rainbow Clinic where families can attend for their review appointments but also where they can attend for care in subsequent pregnancies. The clinic also supports women who have suffered recurrent miscarriage. A Rainbow Clinic is currently available in Wrexham; however, plans are in place to introduce them in Glan Clwyd and Gwynedd hospitals.

New Endometriosis Nurses to Improve Awareness & Diagnosis in North Wales

Two specialist endometriosis nurses have been appointed to help improve services across North Wales for the chronic condition, which affects one in ten women. Clair Masters and Becky Jones have now taken up their roles and will spend time with patients and clinicians to improve services and work together to share best practice. Each Health Board in Wales has now appointed specialist endometriosis nurses, which are funded by a £1m per annum investment from the Welsh Government as part of winder plans to improve women's health services.

Health Minister, Eluned Morgan, said: "Endometriosis affects one in ten women. It can cause serious pain and can seriously impact the quality of life for women affected by the condition. "Our Women's Health Implementation Group is progressing vital work to support women's health and the appointment of dedicated endometriosis nurses in each health board will help raise awareness, diagnosis and treatment of this serious condition across Wales."

Mother praises Ysbyty Gwynedd Midwifery Team after Baby's Safe Arrival

A mother who faced a traumatic birth during the delivery of her son has applauded the midwives who supported her and helped him come into the world safely. Mother-of-four, Amy Eve Macdonald, from Bangor, was expecting a relatively normal birth after no complications with her previous children.

However, on 19 October 2021, Amy went into labour and was admitted to Llifon Ward at Ysbyty Gwynedd where she was informed that due to the positioning of the baby she was unable to have a natural birth and would need an emergency caesarean.

Her baby, Charlie Alex Emlyn Lewis, was born safely and healthy but unfortunately, Amy needed two blood transfusions after losing two and a half litres of blood during the operation. Speaking of her time in the hospital, Amy said: "Although it was a very traumatic birth I cannot praise the team at Ysbyty Gwynedd for the care and support they gave me. "The

midwives at Ysbyty Gwynedd were absolutely incredible, during my induction, my labour, during the section and after we both arrived back onto the ward.

Fiona Giraud, Director of Midwifery and Women's Services at Betsi Cadwaladr University Health Board, said: "International Day of the Midwife is a great opportunity for us to say how exceptionally proud we are of the way our maternity teams continue to provide great care for our mums and babies in the safest possible way.

More than 1.6 million COVID-19 Vaccinations given to people living or working in North Wales

More than 1.6 million COVID-19 vaccinations have now been given to people living or working in North Wales. This significant achievement is down to the hard work of our staff and volunteers and has played a key part in the response to the COVID-19 pandemic.

So far, 50,000 more jabs have been delivered as part of the spring booster phase – the most in Wales – with plans now being put in place for the wider round of booster vaccinations to be delivered in the Autumn.

Gill Harris, Deputy Chief Executive of Betsi Cadwaladr University Health Board, said: "The incredible efforts of our staff, primary care contractors, partner organisations and volunteers have helped us to keep the momentum going on what has been the biggest vaccination programme ever delivered by the NHS. "It has been the success of the vaccination rollout that has helped to significantly reduce the number of people dying or needing hospital treatment with the virus, and ultimately return to a more normal way of life.

Landmark Audiology Patient said switching on implant was "like being put into a video game"

A woman who received a hospital audiology department's 500th cochlear implant said she felt like she'd been plunged "into a video game" when it was activated.

Nicole Milton, 47, underwent an operation to have the auditory implant fitted on April 21 at Glan Clwyd Hospital. The big switch-on came on Tuesday, May 17, and Nicole, whose hearing had gradually deteriorated since childhood, was almost overwhelmed by the sound. She said: "It was like, at the switch of a button, I had been put into a video game. It was only in the car going home it became bearable. "By the time I got home it was just weird – I could never remember hearing so good. I've got a memory of most sounds but that part of my brain had been lying dormant for years."
The unit at Glan Clwyd Hospital is contracted to fit the implants and monitor the progress of patients across Merseyside, West Cheshire and Mid Wales - in addition to serving the North Walian population.

After helping their 500th patient via the procedure, the audiology team is justifiably proud of the difference it makes to people's lives. Nicole agrees it has been a life changing experience. She said: "The difference now is amazing."

Quick-time referrals speeding up cancer diagnosis in North Wales

New rapid Diagnosis Clinics in North Wales will help to diagnose patients with concerning symptoms more quickly as part of nationwide work to cut cancer-waiting times.

Rapid Diagnosis Clinics are now established at Glan Clwyd Hospital, Wrexham Maelor Hospital and from April the clinics will start at Ysbyty Gwynedd. Dr Daniel Menzies, Consultant in Respiratory Medicine at Glan Clwyd Hospital, said: "The Rapid Diagnosis Clinics provide clarity for the patient and certainty for the GP and hopefully allows us to pick up cancers earlier than we would normally.

Minister for Health and Social Services Eluned Morgan added: "With one in two people developing some form of cancer in their lifetime, improving outcomes for cancer patients in Wales is one of the NHS Wales' top priorities. "It is fantastic to see such innovative work being introduced, including rapid diagnostic clinics and other programmes to increase capacity, speed up diagnosis and reduce anxiety for patients at a potentially difficult time in their lives. "This has been a really challenging time for our health service but I am pleased to see work being carried out to improve cancer services for the better."

New Urgent Primary Care Centres will help to reduce pressures on GPs and Emergency Department

Three new Urgent Primary Care Centres (UPCC) will be located across Gwynedd and Anglesey to help reduce pressures on GPs and Ysbyty Gwynedd's Emergency Department. The Health Board has been successful in obtaining Welsh Government funding to provide the service that will replicate the UPCC already established in Wrexham & Flintshire. The initiative will deliver three primary care centres at Ysbyty Alltwen, Ysbyty Penrhos Stanley and within the outpatients department at Ysbyty Gwynedd.

The service will operate Monday to Friday between 9am – 6pm. Outside of these hours, the existing GP Out of Hours service will continue to support patients who do not require emergency care.

Eleri Evans, Head of Nursing for Emergency Care at Ysbyty Gwynedd, said: "We are very excited to be working on this project with our colleagues within Primary Care. "In time, patients will be able to manage their conditions in a more appropriate way by attending the right place and be seen by the right service at the right time. "We are looking forward to working with the primary care team in order to develop the service together."

Report title:	YGC Improvement Plan		
Report to:	Quality, Safety & Experience		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	3.7
Executive Summary:	This report provides an update on the YGC Improvement Plan, describing the improvement approach that is being undertaken and providing assurance on progress to date. The plan brings a structured methodology to improvement work, supported by the Transformation and Improvement team and with the Deputy CEO as the SRO for the programme of work. Delivery of the plan will be overseen via a Programme Board structure, currently being finalised. The plan is underpinned by detailed analysis and triangulation of multiple sources of information including various historical reports. The 5 pillars – "workstreams" - of the plan reflect the thematic elements of the analysis/triangulation, creating a structured and co-ordinated programme of work. Moving forwards this will be recognised as the only improvement plan for YGC, and one that acknowledges that a collective, co-ordinated site wide approach that addresses the root causes is the only way to proceed. However at this current stage there are additional immediate assurance plans in place which will be subsumed into this overarching YGC Improvement Plan at the appropriate point of assurance over the next 3 months. The approach has been road tested with key national stakeholders, including HIW, Welsh Audit Office, Delivery Unit and Welsh Government, who have supported it as an appropriate approach to address the underlying challenges that remain extant. The Plan is a critical element of the Health Board's response to the Targeted Intervention status for YGC.		
Recommendations:	The committee is asked to endorse the approach being undertaken. The committee is also asked to endorse the structure of the plan which is based upon thematic and temporal triangulation and includes key outcome measures. To note the progress to date in developing the plan and agree a schedule of further updates.		
Executive Lead:	Dr Chris Stockport, Executive Director Transformation, Strategic Planning, and Commissioning; Gill Harris, Deputy CEO and Executive Director of Integrated Clinical Services (SRO)		
Report Author:	Geraint Parry, Quality Improvement Fellow, YGC		
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒

Assurance level:	Significant	Acceptable	Partial	No Assurance
	☐	☐	☒	☐
	High level of confidence/evidence in delivery of existing mechanisms / objectives	General confidence/evidence in delivery of existing mechanisms / objectives	Some confidence/evidence in delivery of existing mechanisms / objectives	No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

There are a range of challenges identified by key external stakeholders with remedial action currently being undertaken through immediate assurance plans.

This YGC Improvement plan however is considered to be robust with strong collaboration across executive functions, and with the HMT, to ensure the plan is built from the ground up and is owned by the site. Evidence based approaches to improvement, and programme management have been adopted throughout. However we are within the first few months, and on that basis have scored assurance as 'Partial'. It is anticipated that the HMT will achieve early traction with the delivery of the plan and that assurance will move to an acceptable level within 3 months.

Link to Strategic Objective(s):	6 goals for Urgent and Emergency Care
Regulatory and legal implications	This plan addresses the improvements identified as being required by HIW.
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	CRR Ref 3873 – Inability to deliver safe, timely and effective care CRR 20.06 – Record keeping
Financial implications as a result of implementing the recommendations	Additional support is being provided through Improvement Cymru and the national 6 Goals for Urgent and Emergency Care is being provided to support this improvement activity and to support early traction.
Workforce implications as a result of implementing the recommendations	Any workforce implications arising as the Improvement Plan progresses will be addressed through linkages with the respective EDGs and Executive Team.
Feedback, response, and follow up summary following consultation	The paper has been through an iterative development process with executive team members, the YGC HMT and with external partners through a joint Risk Summit, chaired by the Health Board Chair with Independent Members present. The plan has been supported at every stage with additional detail added as further correlation takes place.
Links to BAF risks: (or links to the Corporate Risk Register)	CRR Ref 3873 – Inability to deliver safe, timely and effective care CRR 20.06 – Record keeping

Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:

Implementation of recommendations, set up of Programme Board arrangements and agreement on future updates.

List of Appendices:

Appendix 1 – YGC Improvement Plan

YGC Improvement Plan

5 July 2022

Historical and current context

Background

Recent months have seen a number of external concerns being raised with regard to services at Glan Clwyd Hospital. These include concerns regarding the Vascular Service, and the Emergency Department.

Both services have commenced improvement plans.

However, these concerns must also be placed into context as there are elements of the concerns in both Vascular and ED that are likely to apply more widely on site than in those two respective services.

We concluded that a wider triangulation of information was required to inform a **YGC wide improvement plan.**

Triangulation

A triangulation exercise has been completed, with

Thematic triangulation to identify site themes and areas of greatest concern.

Temporal triangulation to identify which previous improvement approaches have been successful and resulted in embedded change.

Multiple sources of information have been used in order to triangulate findings.

Sources of information have included (but not limited to):

HIW reports	Concerns, complaints, patient stories	The Royal College of Surgeons Vascular review and associated materials
Public Services Ombudsman reports	Legal and Risk reports	Data available from the BCU Performance Team, and WG
SUI investigations	Coroner reports, including Regulation 28	The BCU Quality Review assessment of YGC in October 2020
Workforce data	Behaviour and Performance management	Improvement Cymru feedback

Triangulation

Confirmed the value of taking a YGC-wide approach

Required a short-term improvement but supported by a longer-term approach that would better secure embedded changes in practice

Required an approach steeped and disciplined in improvement science

Informed a plan built around 5 main workstream **themes**

- Back to basics
- Leadership, empowerment, culture and OD
- ED, medicine, and flow
- Vascular, and theatres
- Audit, outcome and assurance

Current position

Immediate action plans continue to be actively addressed

Alongside, a substantive **YGC Improvement Plan** is being implemented which will

- incorporate the progress made in the immediate action plans for ED and Vascular, to take a site-wide and longer-term approach,

- be structured around the 5 key themes referred to in the previous slide

- be built upon improvement best-practice

- have a focus upon high-assurance, corroborated, evidence of embedded improvement

Future plans and actions

Improvement Methodology

Firm approach to evidence-based methodology, bringing in

- Institute of Healthcare Improvement (IHI),
- Managing Successful Programmes (MSP), and
- Kaizen/Lean theory

Dedicated QI lead
Dedicated Programme Director

Commitment from our Q&I practitioner team to prioritise. Additional capacity would significant help but would need to be in support of, not in parallel

Grip and Control

We recognise there is a need to increase 'grip and control' to support delivery and subsequent assurance.

Significant element of stream 1 (Back to basics) is about ensuring the on-site infrastructure and processes are in place to allow appropriate grip, control and remedial intervention.

Includes:

- HMT diagnostic and support plan
- Refresh of HMT PADRs and objectives to reflect the Improvement Plan
- Incorporation of relevant parts of Improvement Plan in all PADRs on site
- SRO monitoring meetings (initially weekly) in place as part of programme architecture.
- Regular on-site Executive & IM presence

Reporting lines

Note:
Draft version 3
Finalisation conversations underway

SMART outputs

KPIs clearly demonstrating change is occurring

Robust timescales, programmed and reported against

Health Board

Quality & Safety Committee

Targeted Intervention scrutiny

YGC IP Scrutiny Board

Programme Monitoring Report

SRO Oversight

PMO Oversight

Executive Team

Outline Plan Architecture

5 Streams of work, connected in to relevant current Transformation programmes,

plus one additional pan-BCU Transformation programme

Gill Harris
Project Sponsor

Neil Rogers Site AO	**Tracey Foster** Programme (Technical) Director	**Geraint Parry** BCU QI Fellow (YGC Improvement)	Director of Quality & Safety

Stream 1: Back to Basics	Stream 2: Leadership, Empowerment, Culture & OD	Stream 3: ED, Medicine & Flow	Stream 4: Vascular & Theatres	Stream 5: Audit, Outcomes & Assurance

BCU QI Fellow (Theatres)

Assoc Director Governance *(commencing Jul22)*

Subthemes for Stream 1

Subthemes for Stream 2

Subthemes for Stream 3

Gill Harris
Project Sponsor

| **Neil Rogers**
Site AO | **Tracey Foster**
Programme (Technical)
Director | **Geraint Parry**
BCU QI Fellow
(YGC Improvement) | Director of
Quality & Safety |

Stream 1:
Back to Basics

Stream 2:
Leadership, Empowerment, Culture & OD

Stream 3:
ED, Medicine & Flow

Stream 4:
Vascular & Theatres

Stream 5:
Audit, Outcomes & Assurance

3.1 Safety Huddles	3.7 SDEC
3.2 Paediatric ED	3.8 Medication
3.3 Key Opportunity pathways	3.9 Medical Emergency Team
3.4 START model	3.10 Discharge Processes
3.5 Frailty model	3.11 USC Programme interfacing
3.6 Urgent Primary Care	

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

Subthemes for Stream 4

Subthemes for Stream 5

Gill Harris
Project Sponsor

Neil Rogers
Site AO

Tracey Foster
Programme (Technical)
Director

Geraint Parry
BCU QI Fellow
(YGC Improvement)

Director of
Quality & Safety

Stream 1:
Back to Basics

Stream 2:
Leadership, Empowerment,
Culture & OD

Stream 3:
ED, Medicine & Flow

Stream 4:
Vascular & Theatres

Stream 5:
Audit, Outcomes & Assurance

5.1
PROMs and PREMs

5.5
Triangulation

5.2
Audit & reaudit programme

5.6
Floor walks

5.3
Internal site escalation

5.7
Corporate governance
programme

5.4
Corporate escalation

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

Subtheme actions

Gill Harris
Project Sponsor

Neil Rogers	Tracey Foster	Geraint Parry	Director of
Site AO	Programme (Technical) Director	BCU QI Fellow (YGC Improvement)	Quality & Safety

Stream 1: Back to Basics	Stream 2: Leadership, Empowerment, Culture & OD	Stream 3: ED, Medicine & Flow	Stream 4: Vascular & Theatres	Stream 5: Audit, Outcomes & Assurance

1.1 Hospital Management Team	1.4 Audit
1.2 Clinical record standards	1.5 '5 Harms' programme
1.3 Staff rota management	1.6 Complaints management

1.2	Clinical record standards	
1.2.1	Minimum record expectations	BCU minimum record expectations policy collated and published, based upon national practice guidelines.
1.2.2	YGC clinical record dissemination and improvement plan	Agreed plan for implementation of BCU minimum record expectations poligy in YGC, including training programme where required, with completion date being for implementation across entire site
1.2.3	Design of rolling records audit for YGC	Audit plan designed that covers all areas of YGC, and all professions, running on a continual, cyclical basiis
1.2.4	Outcome reporting of rolling records audit	Reporting of rolling records audit on regular basis, with evidence of remediation and escalation having occurred where appropriate. Incorporates HIW1-49
1.2.5	ED specific clinical documentation	Specific programme to rollout BCU minimum record expectations policy, with training programme. Incorporates HIW1-21, HIW1-22, HIW1-51, HIW1-52, HIW1-53,
1.2.6	Confidential record keeping processes	Specific programme to remind staff of storage of confidential records. Incorporates HIW1-54, HIW1-55, HIW1-56, HIW1-57

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

A note on the sub-theme actions

Around 90 actions currently agreed, or close to being agreed, grouped into the sub-themes and then themes. This number will change.

HIW immediate actions are now included for longer-term embedding
(noting concurrent immediate action plans are progressing).

The majority of the SMART outputs, monitoring KPIs, and timescales are being agreed for each action this week.

Governance and Assurance

Governance and Assurance

- Aligned to the three lines of defence model.

- Brings together and aligns key governance processes e.g. a more robust performance and accountability framework.

- Allows for primary routes of escalation, with secondary routes for backup

- Introduces duty to escalate and cascade.

- Introduces local responsibility/leadership for governance linked to corporate function.

Governance and Assurance

- Enhanced and co-ordinated delivery structures throughout the Health Board providing evidence based assurance.

- Consistent and co-ordinated delivery of Health Board strategic objectives, supporting strategies, and Board priorities throughout the structure.

- Defined structures throughout the Health Board (any variances to be centrally agreed).

- Flexibility to allow for local prioritisation (local prioritisation would trigger the duty to escalate).

- Floor to Board via multiple routes (e.g. Line management, Delivery Groups, Performance meetings etc.), for Board Assurance, incorporating deep dives, and board to ward quality dashboards.

- The refresh and strengthening of the ward to board dashboard including the data sources

- Working with external bodies to validate assurance, in line with 3 lines of defence model

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

Governance and Assurance

- Utilises the 3 lines of defence model – assurance not reliant on line management alone.

- Enhanced, centrally co-ordinated compliance monitoring mechanism triangulating quality and safety of all regulators that regulate Trust's activity.

- Integrated assurance approach to enable a more proactive risk mitigation process.

- Proactively review, triangulate and escalate through line management and delivery structure.

- Quality assurance (evidence based) of implementation of local action plans and ensure learning is shared across the Health Board.

- Three line of defence check and challenge within each level and between levels of the Health Board

- Alignment to the Targeted Intervention framework

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

Reporting lines

Note:
Draft version 3
Finalisation conversations underway

Health Board

Quality & Safety Committee

Targeted Intervention scrutiny

YGC IP Scrutiny Board

SMART outputs

KPIs clearly demonstrating change is occurring

Robust timescales, programmed and reported against

Programme Monitoring Report

SRO Oversight

PMO Oversight

Executive Team

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

Progress to Date

High level Gantt

		Week beginning:	23-May-22	30-May-22	06-Jun-22	13-Jun-22	20-Jun-22	27-Jun-22	04-Jul-22	11-Jul-22	18-Jul-22	25-Jul-22	01-Aug-22	08-Aug-22	15-Aug-22	22-Aug-22	29-Aug-22	05-Sep-22	12-Sep-22	19-Sep-22	26-Sep-22	03-Oct-22	10-Oct-22	17-Oct-22	24-Oct-22	31-Oct-22	07-Nov-22	14-Nov-22
		Week no:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26

Preparatory phase	Task	Status
	Agree Scope & main workstreams	Complete
	Commit to Programme methodology & taxonomy	Complete
	SRO agreed	Complete
	Programme director appointed	Complete
	Programme QI fellow appointed	Complete
	Committed additional programme support	On-track. 75% complete
	Workstream leads agreed, with dedicated time	Complete
	Sub-streams agreed	Complete
	Sub-stream PIDs in place	On-track. 66% complete

Stream 1	Workstream 1: Back to basics
	Structured programme of work underpinning each sub-stream PID
	Populated Gantt to reflect sub-stream components
	Programme fully underway

Stream 2	Workstream 2: Leadership, empowerment, culture & OD
	Structured programme of work underpinning each sub-stream PID
	Populated Gantt to reflect sub-stream components
	Programme fully underway

Stream 3	Workstream 3: ED, Medicine & Flow
	Structured programme of work underpinning each sub-stream PID
	Populated Gantt to reflect sub-stream components
	Programme fully underway

Stream 4	Workstream 4: Vascular and theatres
	Structured programme of work underpinning each sub-stream PID
	Populated Gantt to reflect sub-stream components
	Programme fully underway

Stream 5	Workstream 5: Audit, Outcomes & Assurance
	Structured programme of work underpinning each sub-stream PID
	Populated Gantt to reflect sub-stream components
	Programme fully underway

Dark squares = completed

Light squares = still to complete

Detailed stream Gantt's being populated currently

(as per previous slides)

Progress to Date

- Risk Summit held with key stakeholders to confirm approach

- QI Fellow appointed to support the site

- Programme Lead in place to oversee the project plan

- Workstream leads identified for each of the 5 sections of the plan

- Objective setting with HMT

- Development of detailed set of objectives to underpin each workstream

- Outcome measures in place (confirmed for 2 streams, final drafts for remaining)

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

Immediate Priorities

Immediate Priorities

- Increased daily HMT led walkabouts, evidenced through proforma completion incorporating record of remedial action taken

- Augmentation of SOPs for the
    - ED START model
    - ED Safety huddles
    - SDEC & SDEC direct streaming
    - ED staffing model
    - Record keeping

.... accompanied by augmented monitoring of adherence* to the SOPs
* and course correction if required

- HMT development programme

- HIW immediate improvement plan progress

Immediate Priorities

- Increased daily HMT led walkabouts, evidenced through proforma completion incorporating record of remedial action taken

- Augmentation of SOPs for the
    - ED START model
    - ED Safety huddles
    - SDEC & SDEC direct streaming
    - ED staffing model
    - Record keeping

.... accompanied by augmented monitoring of adherence* to the SOPs
* and course correction if required

- HMT development programme

- HIW immediate improvement plan progress

Augmentation completed, and active monitoring in place, due by Friday 1st July

Immediate Priorities Cont.

- Set up of YGC Improvement Plan Scrutiny Board

- Finalised governance schema

- Incorporation of external support

- Finalisation of outcome measures for streams 2, 4 and 5.

YGC Improvement Plan

5 July 2022

Historical and current context

Background

Recent months have seen a number of external concerns being raised with regard to services at Glan Clwyd Hospital. These include concerns regarding the Vascular Service, and the Emergency Department.

Both services have commenced improvement plans.

However, these concerns must also be placed into context as there are elements of the concerns in both Vascular and ED that are likely to apply more widely on site than in those two respective services.

We concluded that a wider triangulation of information was required to inform a **YGC wide improvement plan.**

Triangulation

A triangulation exercise has been completed, with

Thematic triangulation to identify site themes and areas of greatest concern.

Temporal triangulation to identify which previous improvement approaches have been successful and resulted in embedded change.

Multiple sources of information have been used in order to triangulate findings.

Sources of information have included (but not limited to):

HIW reports	Concerns, complaints, patient stories	The Royal College of Surgeons Vascular review and associated materials
Public Services Ombudsman reports	Legal and Risk reports	Data available from the BCU Performance Team, and WG
SUI investigations	Coroner reports, including Regulation 28	The BCU Quality Review assessment of YGC in October 2020
Workforce data	Behaviour and Performance management	Improvement Cymru feedback

Triangulation

Confirmed the value of taking a YGC-wide approach

Required a short-term improvement but supported by a longer-term approach that would better secure embedded changes in practice

Required an approach steeped and disciplined in improvement science

Informed a plan built around 5 main workstream **themes**

- Back to basics
- Leadership, empowerment, culture and OD
- ED, medicine, and flow
- Vascular, and theatres
- Audit, outcome and assurance

Current position

Immediate action plans continue to be actively addressed

Alongside, a substantive **YGC Improvement Plan** is being implemented which will

- incorporate the progress made in the immediate action plans for ED and Vascular, to take a site-wide and longer-term approach,

- be structured around the 5 key themes referred to in the previous slide

- be built upon improvement best-practice

- have a focus upon high-assurance, corroborated, evidence of embedded improvement

Future plans and actions

Improvement Methodology

Firm approach to evidence-based methodology, bringing in
- Institute of Healthcare Improvement (IHI),
- Managing Successful Programmes (MSP), and
- Kaizen/Lean theory

Dedicated QI lead
Dedicated Programme Director

Commitment from our Q&I practitioner team to prioritise. Additional capacity would significant help but would need to be in support of, not in parallel

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

Grip and Control

We recognise there is a need to increase 'grip and control' to support delivery and subsequent assurance.

Significant element of stream 1 (Back to basics) is about ensuring the on-site infrastructure and processes are in place to allow appropriate grip, control and remedial intervention.

Includes:

- HMT diagnostic and support plan
- Refresh of HMT PADRs and objectives to reflect the Improvement Plan
- Incorporation of relevant parts of Improvement Plan in all PADRs on site
- SRO monitoring meetings (initially weekly) in place as part of programme architecture.
- Regular on-site Executive & IM presence

Taxonomy

Themes x5

Subthemes

Subtheme **actions**

SMART outputs

KPIs clearly demonstrating change is occurring

Robust timescales, programmed and reported against

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

Reporting lines

Note:
Draft version 3
Finalisation conversations underway

SMART outputs

KPIs clearly demonstrating change is occurring

Robust timescales, programmed and reported against

Programme Monitoring Report

SRO Oversight

PMO Oversight

Health Board

Quality & Safety Committee

Targeted Intervention scrutiny

YGC IP Scrutiny Board

Executive Team

Outline Plan Architecture

5 Streams of work, connected in to relevant current Transformation programmes,

plus one additional pan-BCU Transformation programme

Gill Harris
Project Sponsor

Neil Rogers Site AO	**Tracey Foster** Programme (Technical) Director	**Geraint Parry** BCU QI Fellow (YGC Improvement)	Director of Quality & Safety

Stream 1: Back to Basics	Stream 2: Leadership, Empowerment, Culture & OD	Stream 3: ED, Medicine & Flow	Stream 4: Vascular & Theatres	Stream 5: Audit, Outcomes & Assurance

BCU QI Fellow
(Theatres)

Assoc Director Governance
(commencing Jul22)

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

Subthemes for Stream 1

Gill Harris
Project Sponsor

Neil Rogers
Site AO

Tracey Foster
Programme (Technical)
Director

Geraint Parry
BCU QI Fellow
(YGC Improvement)

Director of
Quality & Safety

Stream 1:
Back to Basics

Stream 2:
Leadership, Empowerment,
Culture & OD

Stream 3:
ED, Medicine & Flow

Stream 4:
Vascular & Theatres

Stream 5:
Audit, Outcomes & Assurance

1.1
Hospital Management Team

1.4
Audit

1.2
Clinical record standards

1.5
'5 Harms' programme

1.3
Staff rota management

1.6
Complaints management

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

13

Subthemes for Stream 2

Subthemes for Stream 3

Gill Harris
Project Sponsor

Neil Rogers
Site AO

Tracey Foster
Programme (Technical)
Director

Geraint Parry
BCU QI Fellow
(YGC Improvement)

Director of
Quality & Safety

Stream 1:
Back to Basics

Stream 2:
Leadership, Empowerment,
Culture & OD

Stream 3:
ED, Medicine & Flow

Stream 4:
Vascular & Theatres

Stream 5:
Audit, Outcomes & Assurance

3.1
Safety Huddles

3.7
SDEC

3.2
Paediatric ED

3.8
Medication

3.3
Key Opportunity pathways

3.9
Medical Emergency Team

3.4
START model

3.10
Discharge Processes

3.5
Frailty model

3.11
USC Programme interfacing

3.6
Urgent Primary Care

GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Subthemes for Stream 4

Gill Harris — Project Sponsor

Neil Rogers Site AO	**Tracey Foster** Programme (Technical) Director	**Geraint Parry** BCU QI Fellow (YGC Improvement)	Director of Quality & Safety

Stream 1: Back to Basics	**Stream 2:** Leadership, Empowerment, Culture & OD	**Stream 3:** ED, Medicine & Flow	**Stream 4:** Vascular & Theatres	**Stream 5:** Audit, Outcomes & Assurance

4.1 HIW specific actions

4.2 Vascular model & team devel.

4.3 Theatres QI fellow

4.4 OPD modernisation

4.5 Planned Care programme

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

Subthemes for Stream 5

Gill Harris
Project Sponsor

Neil Rogers	Tracey Foster	Geraint Parry	Director of
Site AO	Programme (Technical)	BCU QI Fellow	Quality & Safety
	Director	(YGC Improvement)	

Stream 1:
Back to Basics

Stream 2:
Leadership, Empowerment,
Culture & OD

Stream 3:
ED, Medicine & Flow

Stream 4:
Vascular & Theatres

Stream 5:
Audit, Outcomes & Assurance

5.1
PROMs and PREMs

5.5
Triangulation

5.2
Audit & reaudit programme

5.6
Floor walks

5.3
Internal site escalation

5.7
Corporate governance
programme

5.4
Corporate escalation

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

Subtheme actions

Gill Harris — Project Sponsor

| Neil Rogers Site AO | Tracey Foster Programme (Technical) Director | Geraint Parry BCU QI Fellow (YGC Improvement) | Director of Quality & Safety |

| Stream 1: Back to Basics | Stream 2: Leadership, Empowerment, Culture & OD | Stream 3: ED, Medicine & Flow | Stream 4: Vascular & Theatres | Stream 5: Audit, Outcomes & Assurance |

1.1 Hospital Management Team	1.4 Audit
1.2 Clinical record standards	1.5 '5 Harms' programme
1.3 Staff rota management	1.6 Complaints management

1.2	Clinical record standards	
1.2.1	Minimum record expectations	BCU minimum record expectations policy collated and published, based upon national practice guidelines.
1.2.2	YGC clinical record dissemination and improvement plan	Agreed plan for implementation of BCU minimum record expectations poligy in YGC, including training programme where required, with completion date being for implementation across entire site
1.2.3	Design of rolling records audit for YGC	Audit plan designed that covers all areas of YGC, and all professions, running on a continual, cyclical basiis
1.2.4	Outcome reporting of rolling records audit	Reporting of rolling records audit on regular basis, with evidence of remediation and escalation having occurred where appropriate. Incorporates HIW1-49
1.2.5	ED specific clinical documentation	Specific programme to rollout BCU minimum record expectations policy, with training programme. Incorporates HIW1-21, HIW1-22, HIW1-51, HIW1-52, HIW1-53,
1.2.6	Confidential record keeping processes	Specific programme to remind staff of storage of confidential records. Incorporates HIW1-54, HIW1-55, HIW1-56, HIW1-57

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

A note on the sub-theme actions

Around 90 actions currently agreed, or close to being agreed, grouped into the sub-themes and then themes. This number will change.

HIW immediate actions are now included for longer-term embedding
(noting concurrent immediate action plans are progressing).

The majority of the SMART outputs, monitoring KPIs, and timescales are being agreed for each action this week.

Governance and Assurance

Governance and Assurance

- Aligned to the three lines of defence model.

- Brings together and aligns key governance processes e.g. a more robust performance and accountability framework.

- Allows for primary routes of escalation, with secondary routes for backup

- Introduces duty to escalate and cascade.

- Introduces local responsibility/leadership for governance linked to corporate function.

Governance and Assurance

- Enhanced and co-ordinated delivery structures throughout the Health Board providing evidence based assurance.

- Consistent and co-ordinated delivery of Health Board strategic objectives, supporting strategies, and Board priorities throughout the structure.

- Defined structures throughout the Health Board (any variances to be centrally agreed).

- Flexibility to allow for local prioritisation (local prioritisation would trigger the duty to escalate).

- Floor to Board via multiple routes (e.g. Line management, Delivery Groups, Performance meetings etc.), for Board Assurance, incorporating deep dives, and board to ward quality dashboards.

- The refresh and strengthening of the ward to board dashboard including the data sources

- Working with external bodies to validate assurance, in line with 3 lines of defence model

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

Governance and Assurance

- Utilises the 3 lines of defence model – assurance not reliant on line management alone.

- Enhanced, centrally co-ordinated compliance monitoring mechanism triangulating quality and safety of all regulators that regulate Trust's activity.

- Integrated assurance approach to enable a more proactive risk mitigation process.

- Proactively review, triangulate and escalate through line management and delivery structure.

- Quality assurance (evidence based) of implementation of local action plans and ensure learning is shared across the Health Board.

- Three line of defence check and challenge within each level and between levels of the Health Board

- Alignment to the Targeted Intervention framework

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

Reporting lines

Note:
Draft version 3
Finalisation conversations underway

Health Board

Quality & Safety Committee

Targeted Intervention scrutiny

YGC IP Scrutiny Board

SMART outputs

KPIs clearly demonstrating change is occurring

Robust timescales, programmed and reported against

Programme Monitoring Report

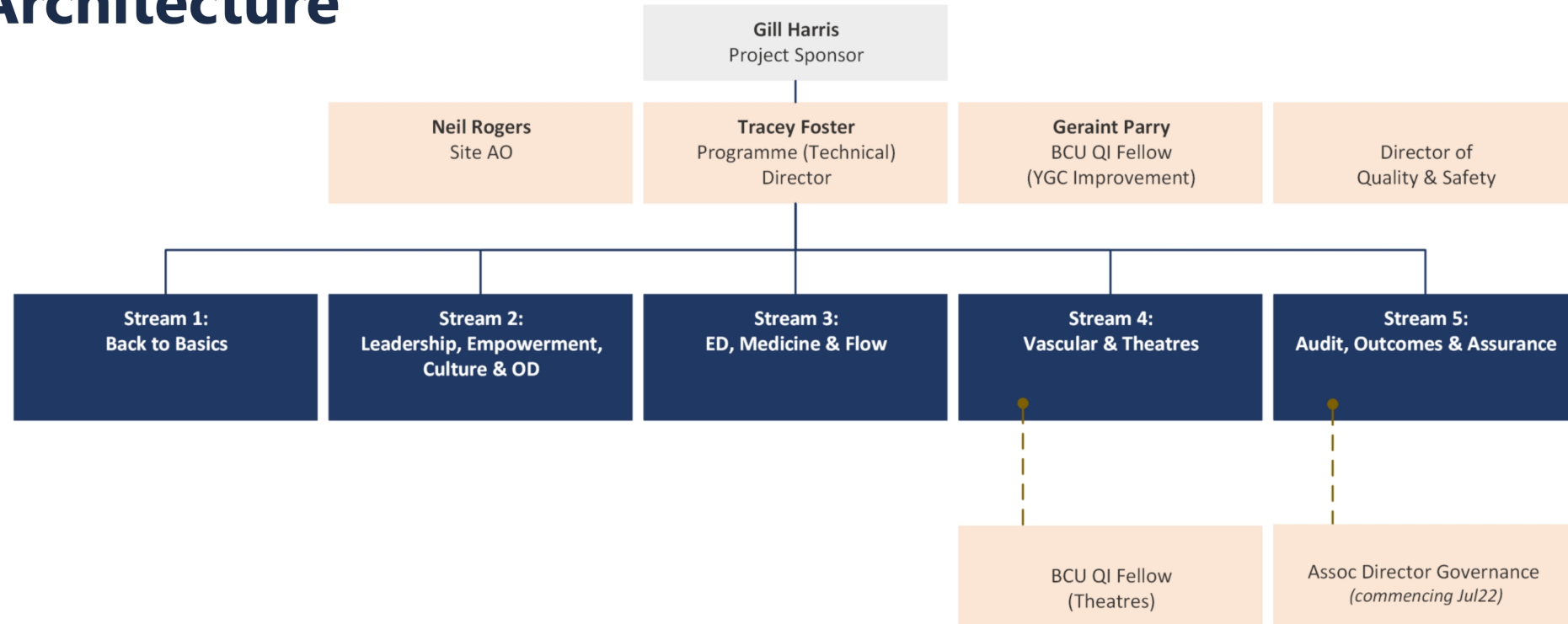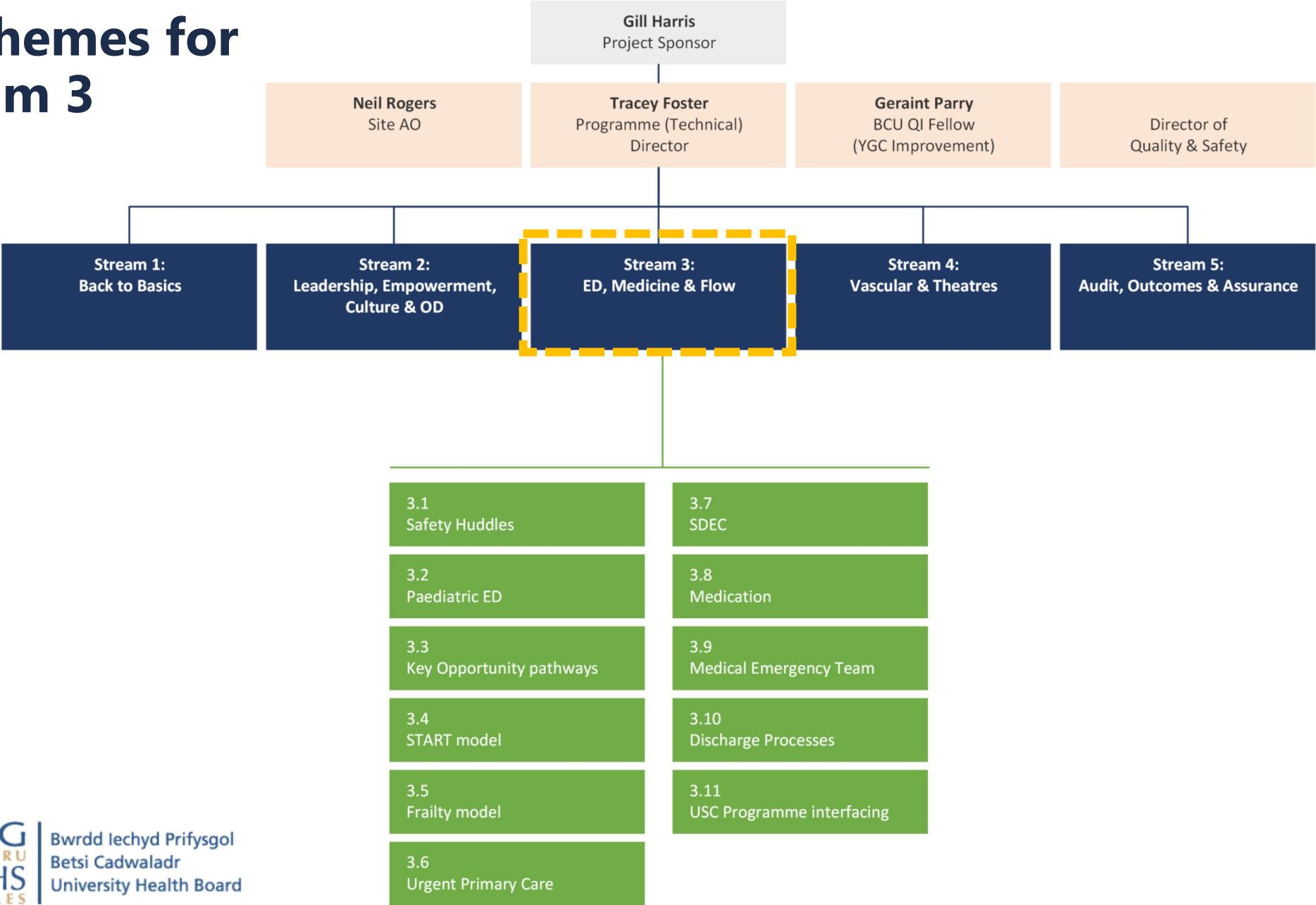SRO Oversight

PMO Oversight

Executive Team

Progress to Date

High level Gantt

Week beginning:	23-May-22	30-May-22	06-Jun-22	13-Jun-22	20-Jun-22	27-Jun-22	04-Jul-22	11-Jul-22	18-Jul-22	25-Jul-22	01-Aug-22	08-Aug-22	15-Aug-22	22-Aug-22	29-Aug-22	05-Sep-22	12-Sep-22	19-Sep-22	26-Sep-22	03-Oct-22	10-Oct-22	17-Oct-22	24-Oct-22	31-Oct-22	07-Nov-22	14-Nov-22
Week no:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26

Preparatory phase

									Complete																	
Agree Scope & main workstreams									Complete																	
Commit to Programme methodology & taxonomy									Complete																	
SRO agreed									Complete																	
Programme director appointed									Complete																	
Programme QI fellow appointed									Complete																	
Committed additional programme support									On-track. 75% complete																	
Workstream leads agreed, with dedicated time									Complete																	
Sub-streams agreed									Complete																	
Sub-stream PIDs in place									On-track. 66% complete																	

Stream 1

Workstream 1: Back to basics
- Structured programme of work underpinning each sub-stream PID
- Populated Gantt to reflect sub-stream components
- Programme fully underway

Stream 2

Workstream 2: Leadership, empowerment, culture & OD
- Structured programme of work underpinning each sub-stream PID
- Populated Gantt to reflect sub-stream components
- Programme fully underway

Stream 3

Workstream 3: ED, Medicine & Flow
- Structured programme of work underpinning each sub-stream PID
- Populated Gantt to reflect sub-stream components
- Programme fully underway

Stream 4

Workstream 4: Vascular and theatres
- Structured programme of work underpinning each sub-stream PID
- Populated Gantt to reflect sub-stream components
- Programme fully underway

Stream 5

Workstream 5: Audit, Outcomes & Assurance
- Structured programme of work underpinning each sub-stream PID
- Populated Gantt to reflect sub-stream components
- Programme fully underway

Dark squares = completed

Light squares = still to complete

Detailed stream Gantt's being populated currently

(as per previous slides)

26

Progress to Date

- Risk Summit held with key stakeholders to confirm approach

- QI Fellow appointed to support the site

- Programme Lead in place to oversee the project plan

- Workstream leads identified for each of the 5 sections of the plan

- Objective setting with HMT

- Development of detailed set of objectives to underpin each workstream

- Outcome measures in place (confirmed for 2 streams, final drafts for remaining)

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

CLOSE DETAIL PAGE

Click here to update this entry

Activity & Descriptor:
3.7.1 - Review the working of SDEC

Clarity is required regarding the YGC SDEC model, leading to an SDEC SOP which will be implemented and monitored.

Activity1: Clearly agree a non-bedded SDEC model and then produce a clear SDEC SOP to ensure it operates correctly
Activity2: Ensure that SDEC checks are incorporated in the HMT floor works (Activity 1.1.4) and check proforma (Activity 5.6.1)
Activity3: Monitor the use of SDEC according to metrics below

Incorporates HIW1-35, HIW1-38, HIW1-39,

Co-dependencies:
1.1.4 - Visibility of HMT on "shop floor" across the site
5.6.1 - Check proforma

Resource requirements:
Analyst support for the metrics below

How will progress be demonstrated (including trajectories where possible):
Activity 2: SOP that describes the model of care for SDEC - uploaded here after agreement with SRO. The SOP should include
- the expected maximum LOS in the SDEC unit.
- criteria for the types of patients suitable for SDEC and an exclusion criteria.
No patient to spend greater than 10 hours in SDEC
The average time from SDEC requesting a bed to be no greater than 1hr
The volume of patients through SDEC each day

Required evidence to be provided:
Activity 2: SOP, agreed by SRO, uploaded here with confirmation that it is operational
Activity 3: Evidence that the metrics are being reviewed, reflected upon, and course correction applied where required - weekly upload here

Team Implications/requirements:
SDEC ward manager. Clinical Leads in Acute Medicine. Head of Nursing. Director of Operations:
-Agree operating model for SDEC with HMT
-Ensure the SOP is followed and that staff understand the importance of this

HMT
-Agree operating model for SDEC with SRO
-Oversee production of SOP, and then roll-out
-Ensure that all YGC Bronze and CSMs understand the SOP is to be adhered to out of hours as well as in hours

How will embedding be demonstrated (including subsequently to the activity being completed):
Activity 3 must continue for at least 26 weeks to support embedding and can only be stopped with SRO approval. Frequency of monitoring report reviews can be reviewed in light of improvements, but will require SRO approval.

Notes added for this activity:

ADD A NEW NOTE

No records found.

Document uploads for this activity:

ADD A NEW DOCUMENT

No records found.

	Start date	Expected duration (wks)	Calculated end date	Status
Action1	20/06/2022	2	04/07/2022	AMBER
Action2	20/06/2022	3	11/07/2022	AMBER
Action3	04/07/2022	26	02/01/2023	AMBER

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

29

Immediate Priorities

Immediate Priorities

- Increased daily HMT led walkabouts, evidenced through proforma completion incorporating record of remedial action taken

- Augmentation of SOPs for the
    - ED START model
    - ED Safety huddles
    - SDEC & SDEC direct streaming
    - ED staffing model
    - Record keeping

.... accompanied by augmented monitoring of adherence* to the SOPs
* and course correction if required

- HMT development programme

- HIW immediate improvement plan progress

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

Immediate Priorities

- Increased daily HMT led walkabouts, evidenced through proforma completion incorporating record of remedial action taken

- Augmentation of SOPs for the
    - ED START model
    - ED Safety huddles
    - SDEC & SDEC direct streaming
    - ED staffing model
    - Record keeping

.... accompanied by augmented monitoring of adherence* to the SOPs
* and course correction if required

- HMT development programme

- HIW immediate improvement plan progress

Augmentation completed, and active monitoring in place, due by Friday 1st July

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

Immediate Priorities Cont.

- Set up of YGC Improvement Plan Scrutiny Board

- Finalised governance schema

- Incorporation of external support

- Finalisation of outcome measures for streams 2, 4 and 5.

Cyfarfod a dyddiad: **Meeting and date:**	Quality Safety and Experience (QSE) Committee 5 July 2022
Cyhoeddus neu Breifat: **Public or Private:**	Public
Teitl yr Adroddiad **Report Title:**	Vascular Steering Group Update 3.9/QS2.220
Cyfarwyddwr Cyfrifol: **Responsible Director:**	Dr Nick Lyons, Executive Medical Director
Awdur yr Adroddiad **Report Author:**	Neil Rogers, Acute Care Director (YGC) Sally Morris Vascular implementation plan adviser (interim)
Craffu blaenorol: **Prior Scrutiny:**	Vascular Steering Group 28th June 2022
Atodiadau **Appendices:**	Updated Vascular Improvement Plan

Argymhelliad / Recommendation:
The committee is asked to receive the update from the Vascular Steering Group

Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer **penderfyniad /cymeradwyaeth** **For Decision/** **Approval**		**Ar gyfer** **Trafodaeth** **For** **Discussion**		**Ar gyfer** **sicrwydd** **For** **Assurance**		**Er** **gwybodaeth** **For** **Information**	**X**
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable**						**N**	

Sefyllfa / Situation:
This monthly report sets out the progress against the Vascular Improvement Plan which is monitored through the Vascular Steering Group and issues escalated through the vascular oversight group.

Cefndir / Background:
The current Vascular Improvement Plan is in response to the RCS review which was in two stages and which identified key areas for concerns around patient care that needed to be addressed.

Asesiad / Assessment & Analysis

For the purpose of this paper the Vascular Improvement plan is appended to this report and as noted in the previous papers the second stage review made 9 recommendations around the need to provide follow up and communication with some patients as a result of the case review. Work continues on the Vascular Improvement Action Plan.

Pathways
The current pathways with vascular involvement have had formal sign off and there a number of historic pathways that now require review. The Professional Vascular Governance Lead for the Health Board, has made rapid progress, driving forward a review of the current clinical pathways, ensuring national clinical standards are embedded in the new pathway designs. This is work in progress and it is anticipated that these will be completed with full clinical engagement from key stakeholders for approval through the BCUHB Clinical Effectiveness Group (CEG). The lead has also reviewed the process for Emergency and Urgent Referrals received by Telephone and proposed a more efficient way of managing this process which will ensure that the patients are cared for in the correct clinical environment; where appropriate patients are seen and treated at the Spoke Sites or transferred to the Arterial Site, maximising the appropriate use of Hub Site capacity.

Audit
Audits of Case-notes are under taken on a regular basis by all three site medical directors. Issues identified are being addressed with the medical staff and progress and lessons learned continue. Improvement has been noted. Some delays remain with letters being typed up in a timely across sites due to vacancies, high level of sickness in all medical secretariat and inability to back fill from bank and agency compounded the

issues. A trial is being undertaken at Glan Clwyd to dictate some ward rounds to improve the quality of documentation and the professional governance lead is leading the team with this incentive.

Second Stage Review Update
As previous papers have set out a multi-professional, independently chaired Vascular Quality Review Panel has been convened. A structured case review is being progressed on the clinical records for the patients who were presented to the RCS review team, as well as the additional records which were due to make up a total of 50 as agreed in the RCS review terms of reference but were then not presented to the RCS review team. It has now been identified that there were two duplicate records and two that did not exist, so records belonging to 47 patients in total are to be reviewed. Stratification of order of review has been undertaken by allocating a red/amber/green status to the records mapped to their feedback from the RCS report. An additional red/red allocation has been added to identify those records which were omitted from the review in July 2021.

Pending the final report, should the Panel identify serious concerns in relation to ongoing or potential risk these are being escalated immediately by the Panel's Chair to the Executive Medical Director or named Director in his absence. Early concerns escalated around standards of documentation have already led to the executive decision to set up a BCUHB Task and Finish Group to take forward the concerns around medical records. This Group will include each of the clinical executives as well as the Chief Digital and information Executive and will focus not only on the vascular notes but on wider note keeping across the Health Board. The Panel has also received an update that the undertaking of a BCUHB review of ward accreditation will also ensure it provides greater assurance on points raised.

The multi-professional panel, held their first meeting on the 6 April 2022 and is continuing to meet weekly. A final member as an external vascular surgical expert is yet to be appointed but it is hoped that this is imminent. A non-medical vascular expert (CNS) has been on the panel since formation. Updated recommendations and concerns from the quality panel will be added to the vascular improvement plan for monitoring and reported into vascular steering group monthly.

The 9 recommendations from the 2nd stage review are as follows:

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

These recommendations, particularly in relation to MDT working, build on the previous recommendations received as part of the first stage of the report in 2021 but also provide additional areas on which to focus improvement. The formal MDT arrangements with LUHFT commenced on the 22nd April and further links are being developed with the anaesthetic teams at LUHFT for shared learning. Some, but not all, of these recommendations are already addressed within the existing Vascular Improvement Plan.

Also included are additional early actions developed with clinical and operational teams to ensure that actions are effective and that lessons are learned not only in the vascular service but also more widely across the Health Board.

These actions include:

- The development of a Vascular Quality Panel that will, with external support and validation, review the clinical notes and carry out additional thematic review of notes as necessary across BCUHB.. Triaging of all notes has taken place to ensure those identified as concerning by the RCS are reviewed first. The panel first met on 6th April and will continue on a weekly basis to discuss all stakeholders' findings and provide feedback to the relevant personnel

- Review of current notes and consent in vascular services (all sites) as well as development of further clinical leadership capacity to oversee and implement standards. This has been completed on a weekly basis and a snapshot audit of 20 notes displayed a marked improvement suing the STAR tool

- Formal agreement to work more closely with Liverpool, particularly in relation to MDT discussions but also in terms of wider standards developed and clinical support

- Development of an open and transparent communication plan in line with Caldicott Principles, including engagement with families and patients within the Quality Panel review process

- Discussions with Welsh Government and regulators of professional practice.

- Support for staff involved in the vascular service but also more widely across the Health Board.

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

28 Day Plan
A 28 day plan was implemented 17th March 2022 – 23rd May 2022 which outlined out of hours support and complex case management. Weekly monitoring was undertaken with regard to the activity and the measures ceased on 23rd May. Focus upon operational performance and backlogs remains and the vascular network director continues to lead the weekly meeting to get an update on vascular services across all 3 sites. Dual surgeon operating for complex open aortic repairs and the support from Liverpool for all highly complex cases remain in place.

Previous Vascular Business Case and the IMTP funding scheme requests
In November 2017 an SBAR was produced requesting funding for a "single operating site for arterial vascular surgery". It did not define the service as a Hub and Spoke Model, and did not include the support required in terms of staffing, estate or workforce for the Spoke sites.

Prior to the changes in April 2019, each of the Spoke sites had up to 18 beds allocated (often spilling out in to General Surgery depending on length of stay) for vascular patients. There were no additional beds put in to the Hub site to reflect the service transfer, and no consideration of changed community/rehabilitation requirements. The pre-existing Spoke site (YG & WMH) vascular beds became absorbed into the general bed stock, predominantly as medicine capacity (due to demand). Despite demand increasing for Vascular beds on the Hub Site, no additional funding was included within the SBAR for ward nursing or therapy. ANPs play a pivotal role on each site, not only in patient care but also within the MDTs, which are essential governance procedures to ensure patient pathways are followed through and in the safe management of AAA surveillance patients. There was no additional funding to ensure the spoke sites had sufficient cover.

The administrative demand on medical secretaries and appointment booking teams across all three site increased after April 2019, as patients are sent back for follow up reviews to their spoke sites. The reduction in the Spoke site vascular medical, nursing and therapy workforce, due to either being transferred to YGC or absorbed into general surgery, has left the infrastructure struggling to keep the service stable.

Outpatient services do not appear to have been considered as part of the change in service model in April 2019, and all three sites have maintained their out-patient demand (significantly increased post Covid). This requires consultant, middle, junior and vascular nursing other associated administrative resources including medical secretariat and waiting list management, AAA surveillance, diagnostic and booking teams. Clinical pathways including diabetic foot and the multiple agency input required across three sites was also not part of the original funding bid.

Current Funding Request
Additional funding has been sought via the IMTP process to balance the current budget shortfall and invest in key areas as identified as gaps including; medical staffing, administrative staffing, therapies, radiology , out-patient book teams, diagnostic tests, ward beds and staffing. A business case is in the process of being written for both the diabetic foot pathways and the vascular improvement programme. There has been a small

increase since the submission for IMTP due to the increased scrutiny and therefore deep dive into vascular processes illustrating resource issues.

Due to the delay in the ability to progress the recruitment for improvement (pending business case approval), there will be slippage in the part year forecast costs for 2022/23. This may also impact upon the planned delivery of the SMART objectives outlined in the IMPT process.

Pathway work
The Diabetic foot pathway has been signed off by all sites, and steps are being taken to provide interim clinical support for this ahead of substantive recruitment and full implementation but is rate limited pending full release of funds. Elements of the pathway can be delivered but the true Multi-disciplinary foot service approach to management of these complex patients requires resource to create the capacity within current job plans to provide.

There will be a quarterly review to identify any deviation from the pathway or poor patient outcomes, to allow for amendments to pathway or process as needed. An SOP is also required to run alongside the diabetic foot pathways and the repatriation pathway to describe how it will be delivered, and by who, and indicative timeframes and escalation processes. This has been requested from specialty teams for completion.

The final historical pathway for sign off is patients requiring an unanticipated overnight stay at spoke sites following vascular day-case procedures; this has been signed off clinically across the sites and has had CEG endorsement as of 21 June 2022.

There are currently 152 actions on the revised vascular improvement plan stemming from 1st and 2nd stage RCS report, NVR report, and from gaining a broader understanding of specialty issues following revision of the plan. 84 of those actions are now complete with further work remaining 52 remaining in progress and 16 with work yet to commence. A number of the actions are reliant upon funding from the vascular improvement funding scheme submitted to IMTP pending business case approval.

The risk register has been reviewed for the vascular service with the interim Clinical Director and the management team, and is aligned with the risk log on the action plan. The identified risks all relate to actions and recommendations within the vascular improvement plan from the 1st stage RCS report and the NVR actions relating to theatre access and bed or ITU bed availability.

Vascular Away Day
There is an away day planned for the 6th July by the vascular network director in conjunction with the transformation team to review the current state and determine the strategy, process and resource required to improve the service with a short, mid tem and longer term view. The day will be supported by the transformation team and working groups will be held to review any current service shortfalls, a shared vision for the future, clarity on priorities, defined work streams for development, clarification on roles and responsibilities, governance framework and a commitment to engage in the vascular programme.

Opsiynau a ystyriwyd / Options considered
The need to ensure external validation and assurance of the effectiveness of actions within the Vascular Improvement plan is currently being considered
Goblygiadau Ariannol / Financial Implications
A detailed proposal of additional workforce requirements to ensure sustainability of the vascular service has been developed for the Integrated Medium Term Plan (IMTP)
Dadansoddiad Risk / Risk Analysis
The risk register has been reviewed as outlined above Reputational risk – high and likely
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Any legal implications in relation to the quality of consent and other issues identified as part of the RCS report are currently being considered. The Health Board is working closely with regulators in relation to professional standards.
Asesiad Effaith / Impact Assessment
Currently under consideration.

GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Infection Prevention Sub Group (IPSG)
Meeting date:	**May and June 2022**
Name of Chair:	May: Rebecca Gerrard, deputising for Gaynor Thomason June: Mandy Jones, deputising for Gaynor Thomason
Responsible Director:	Gaynor Thomason, Interim Executive Director of Nursing and Midwifery
Summary of business discussed:	- IP nurse staffing update provided with an improving picture reported as internal applicants appointed to some vacancies. - Alert, Assurance, Achievement (AAA) reports from areas. - C.difficile data: BCU had lowest rate of all Health Boards in 2021/22 but slightly higher than previous two years. Retrospective audit being carried out to explore C.difficile trends within cancer patients. Also recently seen increase in the re-occurrence of C.difficile infections, so to review all Wales data, genotype links, antimicrobial prescribing and feedback August. - Data being collected in YG on vaccinated and unvaccinated COVID positive patients requiring respiratory support. Unable to collect at YGC and WM due to lack of resource. - Review of new and updated policies, protocols and risk assessments and those that have been withdrawn. Highlighted: New Welsh Health Circular published on AMR and HCAI Improvement goals (targets extended to March 2023). - TB risk in Ukrainians and precautions required. - New letter from CNO re de-escalation of COVID-19 measures and BCU response. - New PHW guidance on IP for COVID-19 in healthcare settings. - New PHW guidance on Monkey pox. Confirmation of BCU approach and agreement to adopt level 2 PPE for suspected cases in addition to confirmed. - Feedback provided on key lessons learnt from HCAI reviews – noted poor medical engagement. - IPSG plan on a page for 2022/23. - Estates Safe Clean Care – Harm Free revenue allocation for 2022/23 for improvements is being prioritised through Local IP Groups. There is also an allocation for Cancer services this year. - Post Infection Review (PIR) process in Primary Care – plan to adapt PIR to improve engagement and collaborative working. - National Estates and Facilities Celebration Day (15th June 22).

	• New Coagulase negative staphylococcus (CNS) blood culture dashboard to support the indication of blood culture contamination rates. **Decontamination:** • Key risks and alerts • New national guidance for cleaning incubators in neonatal units – reviewing BCU protocols to ensure alignment. • Updated Terms of Reference for Decontamination Group.
Key assurances provided at this meeting:	• Learning from the HCAI reviews is being shared widely. • Implementation of new COVID-19 testing guidance across BCU. • Implementation of updated visiting guidance across BCU. • Outbreak management controls in place supported by IP team. • PHW leading research to understand at ward level, what might predict a COVID-19 outbreak e.g. staffing rates, ward turnover, community transmission rates and ventilation. • Acute and area teams are collaborating more closely and producing joint reports in many cases. • MRSA screening is now included in the pre-insertion of PICC pathway in cancer patients; compliance to be monitored. • 'Triclosan' (antimicrobial coated) sutures being implemented for Caesarean sections (NICE guidance 2021). • Recent Local Authority Food Safety Inspections at BCUHB have received positive feedback. • Annual reports received from the Authorising Engineer in Water Safety and in Ventilation are showing improved overall scores compared to previous reports. • Estates and Facilities Annual Compliance Report circulated. • Shared services carried out a review of BCUHB Decontamination facilities in May; to report in July. • Dental antimicrobial formulary complete and for review; pharmacy leads received good engagement from clinical leads.
Key risks including mitigating actions and milestones	• **IP team resource Risk 4241** 'Inability to deliver timely IP services due to limited capacity', scoring 15. Mitigating actions include recruiting to vacant posts, using IP Champions to promote IP, preparing a business case for expanding the current team, designing a development programme for existing IP nurses and promoting the Bangor University IP education programme amongst non-IP staff. • **Over reliance of negative COVID-19 result vs clinical respiratory presentation** – clinicians reminded to conduct full respiratory screening profile and not just consider COVID-19. • **Documentation regarding invasive devices is not robustly completed** e.g. for catheters, blood cultures and vascular access devices. PDNs to make this topic of the month for May. Issue to be included as a SCC-HF project later this year. Spot checks to be completed by Matrons. • **Poor compliance with antimicrobial stewardship** – also poor investigation of source of infection. Feedback given to clinicians. Need renewed focus on 'Start Smart then Focus' audits.

- **Surge capacity impacting on social distancing** – patients screened, risk assessments in place. WM reviewing the ongoing need for pods with IP.
- **Maternity services in community** - IP supported review to enable them to return to bases wherever possible.
- **Caesarean section wound infection post-discharge** - Epidemiologist supporting targeted work to reduce caesarean section wound infection post discharge.
- **Community Dental Services continue to experience challenges related to environmental ventilation and decontamination** – business cases will be required to secure further investment.

Estates and Facilities issues:
- **Challenges with domestic capacity and cleaning** - recruitment campaign and the current resource is being prioritised e.g. to outbreak areas, with support from IP, however, delays in recruitment process is resulting in the loss of appointed applicants. Request for Domestics to be included as a priority recruitment group for workforce support.
- **Two new Estates and Facilities risks** - Tier 3 Waste Segregation (Clinical Waste/General Waste) and Tier 2 Implementation of the New Operating Model.
- **Domestics mandatory training compliance poor –** Carried out pilot partnership with Unison on accessing funding for digital numeracy and literacy. Have purchased and received 40+ iPads for Domestics as they don't currently have access to computers.
- **Slow progress with installing doors on bays** – Local IP Groups (LIPGs) to review requests for improvement for 2022/23 and update estates. Effect on ventilation being considered before doors are added.
- **Insufficient single rooms with appropriate ensuite facilities and community day rooms routinely used for patient escalation** - hierarchy of isolation risk assessment available. New isolation matrix and SOP now launched supported by daily advice from IP on prioritisation.
- **HPV deep clean programmes hindered by the lack of decant space** - Task and finish group to roll out Hypochlorus Acid established. New mobile UVC air purifier to be piloted in YG in June.
- **The procedure for regular flushing of taps and showers that are used infrequently is not robustly undertaken** – the Water Safety Group have drafted a new protocol to clarify the process and will communicate it widely once approved.

Decontamination issues:
- **Decontamination Risk 4325** 'Potential that medical devices are not decontaminated effectively so patients may be harmed', scoring 16. Mitigating actions include to revise Decontamination Group Meeting terms of reference, Policies and SOPs written and approved for decontamination and are being implemented, to

	meet with key individuals to horizon scan for solutions to the issues at YGC and WM, to review and update the risk register. • **Decontamination of ENT scopes** – manual decontamination still in place in YGC (should be contingency only). Deadline for current usage was end June 2022. Alternative suggestions forwarded to relevant stakeholders for consideration and action required and will be followed up by the Decontamination Adviser. • **SSD Electronic Track and Trace contract needs renewing** by August 2022; SDD managers asked to address. • **SSD equipment, air handling units and facilities for Endoscopy/Urology are ageing** – Shared Services carried out review in May. 6-monthly audits are up to date. Risk assessment updated. Reassuringly, there was no disruption to clinical services during temporary closures at YGC and WMH SSDs. • **Choledochoscopes are not sterilised** – only disinfected. Risk to be reviewed by Theatre Managers. Options for sterilising choledochoscopes are being explored. • **Sleep Angel mattresses -** cannot be appropriately inspected for internal contamination. Executive team alerted. Scoping exercise and replacement process in place. • **Decontamination of ophthalmic laser lenses -** new risk to be added to the risk register to describe the controls and mitigations associated with the use of the Tristel wipe system.
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)
Issues to be referred to another Committee	• Summary from IPSG is also sent to PSQ.
Matters requiring escalation to the Board:	• Nil
Well-being of Future Generations Act Sustainable Development Principle	• PHW are supporting BCU with assessment of risks and identifying short and long-term priorities in Decontamination. • Promoting IP education programmes at Bangor University. • Estates and IP trialling new technologies including ATP testing, hypochlorous acid, mobile air purification units, automated hand wash systems and joint working with the University of Sheffield on environmental cleanliness forensics.
Planned business for the next meeting:	Range of regular reports plus • Spending by E&F in relation to improving the environment/IP. • Q1 mandatory training data. • IPSG Annual report. • Update on CAUTI (Catheter associated urinary tract infection).
Date of next meeting:	26th July 2022

V8.0

Clinical Effectiveness Group - Chair's Report to Quality, Safety and Experience Committee (QSE)

Alert Assurance Achievement (AAA) report

Reporting Group	
Name of Reporting Group	Clinical Effectiveness Group (CEG)
Responsible Director	Dr Conrad Wareham, Deputy Medical Director (report submitted by Chair of CEG)
Date of meetings	14th April 2022 and 21st June 2022
Version number	1
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience (QSE) Committee
Date of meeting	7th July 2022
Presented by	Dr Conrad Wareham

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

APRIL MEETING

The April Clinical Effectiveness Group (CEG) meeting was quorate, however due to low numbers in attendance on previous dates, the day of the meeting had now been changed to a Tuesday, moving forward, which will be monitored to ensure attendance is improved.

There were concerns noted that several actions such as completion of the Terms of Reference (TOR) could not be completed due to the need for clarification of organisational structure review.

Action:
To bring them back at later date to CEG meeting, when the new structure was confirmed and the documents could be finalised for review and approval for presenting at the following Quality, Safety Experience (QSE) Committee, in the future.

There was a concern raised that the Ultrasound Governance Group have not had medical representation within the group, and the Overarching Radiation Protection Committee which that group reports to, had asked to bring this to CEG for guidance in who should be supporting this clinical component.   Need clinical users as some governance issues around ultrasound, how they identify and who should it be, which only meets once a quarter, so not a heavy commitment.

Action:
To bring back as an agenda item at August meeting, with paper and proposal steps that need to happen, this was agreed for Helen Hughes, Professional Service Manager Radiography, to present.

JUNE MEETING

Patient Story
Conrad Wareham to arrange group to review position across Health Board completing gap analysis on documents for each single procedure and to include review of Local Safety Standards for Invasive Procedures (LocSSIPs).

Clinical Law & Ethics /End of Life (EoL)
Conrad Wareham, Ben Thomas, Damian McKeon, Gemma Lewis-Williams and Alison Foster to meet and determine specific need and how to proceed as soon as possible and to delegate executive ownership / leadership across the organisational resource

Drug & Therapeutics
Gareth Bowdler to investigate and clarify risk around the lack of access to health records in timely manner due to Wi-Fi issues and how it is being managed.

Central Locality CEG
Tania Bugelli asked for formal escalation to be determined around lack of support for Central CEG meetings – Conrad Wareham and Mandy Jones to work with Tania to draft concerns. Also meeting to be arranged with Neil Rogers to agree how to take forward.

Business Case for Acute Medicine, Wrexham
Meeting to be arranged with Emma Wooley, Conrad and Steve Stanaway to be held as soon as possible to determine how best to progress.

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

APRIL MEETING
The following Chairs reports were received and included in the meeting papers sent to all members prior to the meeting. The authors presenting were not present for the first four noted.

- Reducing Avoidable Mortality Steering Group
- East Locality Clinical Effectiveness Group
- Central Locality Clinical Effectiveness Group
- West Locality Clinical Effectiveness Group
- Medical Education

The Chair asked for the papers to be noted, and referred to each one for any points to the group – nothing was raised.

Draft audit plan was brought to Clinical Effectiveness Group for discussion and to confirm that it would be presented at the Quality, Safety and Experience Group Extraordinary meeting held on 26th May 2022. Tier 1 are mandated audits to be completed and submitted to Welsh Government, and Tier 2 audits significance is that they align as much as possible with organisation priorities and risks. There were discussions on audits that require accreditations in house, which were not included in the Tier 2 list for this year. This raised discussion where updates on these audits should be if not labelled as Tier 2. A decision was made that any audits that fitted this criteria, would be captured within the Cycle of Business (COB) quarterly for feedback to be given on progress and on target to complete for accreditation.

There were a number of policies circulated in advance of the meeting for review and approval, which were noted as read and approved due to meeting being quorate. There were three policies that had not submitted papers in time, which were referred to the June meeting.

It was noted that Pathway for Prescribing Domperidone was to be put on hold as there were points that needed to be clarified, which were clarified in June and the pathway can be resubmitted and approved.

Standard Agenda Items APRIL AND JUNE UPDATE

- Quarter 2 Clinical Effectiveness Report & Quarter 3 Clinical Effectiveness Report – (brought forward to February – for noting) to be taken to Extraordinary meeting on 26th May 2022 QSE meeting.
- Draft Clinical Audit Annual Plan 2022/2023 for discussion was to be taken to Extraordinary meeting on 26th May 2022 QSE and further discussion at the QSE 5th July for ratification. The paper was sent to the group for reference, Tier 1 mandatory so no control over the list presented, Tier 2 going forward will be focused to align with priorities of the health board assurance framework, evolutionary process, currently transient approach to achieve this
- Research & Development Update (verbal update) no comments or actions noted
- Quarterly Mortality Report – no comments or actioned were raised in April, Damian McKeon presented report in June meeting on current work that is going on with developing the mortality framework
- Healthcare–associated infection (HCAI) Covid Death Review Process for Agreement was presented in June by Kim Warrington-Davies. She provided a brief verbal update that in April allocated £878,000 to investigate cases of Covid

19 acquired in hospital or not. 30% of the team were now recruited and in place and reviews of cases started August 2021. The process is being established and currently any investigations within the Health Board of COVID death or a compliant made related to that will be viewed as one investigation. Wanted to provide assurance that process was in place, any reviews of death go to the Quality Assurance Panel which is being established from next month. Reports will go to the mortality meeting on a quarterly basis to feedback findings.

<u>JUNE MEETING</u>

Rachel Wright, Patient Experience and Carers Service Lead and presented a 'patient's story' via video, with regard to procedure Mrs W had received in maxillofacial surgery department in 2021. Mrs W explained that although nursing background, she was nervous with the information she received as mentioned skin graft and left feeling scared. She asked for any leaflet information, and was informed that Mrs W would have more support with queries when attending for the treatment. The patient could not fault the medical care she received throughout the treatment.

As leaving left with half a piece of A4 paper with numbers on and gauze and felt total traumatised by the situation, the patient said there was no written information on facial lesion. Mrs W did her own research on other hospitals and information they provided on similar procedures. As an infection started in the scar, the patient came into the hospital the literature she found, and handed the information to a registered nurse who was very dismissive and replied that she felt 95% of patients would not understand or read the information. Mrs W felt that her experience may help provide support going forward.

The learning since captured patient's story, the following improvement taken place all pre-operative patient leaflets have been reviewed by health boards patient information reader's panel and now is in circulation. Pre-operative and post-operative information is now given verbally and written format to patients, and realise that sometimes it is hard to take all the information in so written information is in a language that accessible to all patients. If they have any other queries they are encourage to contact the service number during office or out of hours to answer any queries. Department is working with informatics to have pre-operative information with their appointment letter, to allow patients time to digest information prior to attending the hospital. Currently there is also a survey being done to look at findings and lessons learnt, findings of this will be shared at the next Clinical Governance meeting, also department is working with communications department to look provide information on SharePoint for staff to access and on the intranet for patients and patients to access. Patient Information readers' panel review on average 10 leaflets a months to ensure all information is being reviewed.

Several points were raised by the group:
- to ensure that followed local guidance pathways, and ensure bi-lingual.
  Rachel confirmed the process that was being followed to provide assurance.

- Was the attitude of the member of staff addressed and a discussion had with them? *Rachel confirmed that that had happened*
- In the absence of an information leaflet you can obtain implied consent to Montgomery standards, and acknowledged work that has been done, but how assured are we that the situation is substantially better over all areas. *Confirmation of auditing consent and as part of that as to whether a leaflet is being submitted, so moving forward data will be gathered so this can be brought at later date to CEG to update.*

A site on SharePoint is due to be launched, will have EIDO and patient information, any leaflets that have been through the information panel will have library page and will sit together.

In June the following Chairs reports were received and included in the meeting papers sent to all members prior to the meeting:

- Clinical Law & Ethics Sub-Group
- Drug & Therapeutics Sub-Group
- Strategic Delivery Group for Palliative and End of Life Care
- East Locality Clinical Effectiveness Group
- Central Locality Clinical Effectiveness Group
- West Locality Clinical Effectiveness Group

The Chair asked for the papers to be noted, and referred to each one for any points to the group – nothing was raised.

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

<u>APRIL MEETING</u>

<u>Reducing Avoidable Mortality Steering Group</u>
- The Framework Panel are now a regular fixture and meet fortnightly. There is a huge potential in this panel for disseminating learning – and a Comms strategy around this is being discussed and evolved. The Panel also allows the opportunity for organisational memory and will produce summative reports.

The current themes emerging:
- Acute Stroke Care- deep dive in terms of triangulating Office of National Statistics (ONS), Comparison Health Knowledge System (CHKS), cases being prepared to highlight some themes around Acute Stroke Provision and time to thrombolysis.
- DNACPR – large percentage of ME cases around this- particularly in light of Covid- visiting restrictions etc. Ben Thomas is doing a huge amount of work around this- so aiming to dovetail into this work rather than create another work stream- but have feedback into the Panel.

- Palliative Care- again on similar lines to above – emerges in multiple areas in ME reports – Gemma Lewis and Alison Foster are looking at this across North Wales- aiming again to feed into the Panel and not duplicate but represent work ongoing and try and disseminate and network support for these initiatives.
- Contribute to National Meeting – Will be presenting the BCUHB interpretation of the Framework- and the particular strength of developing a network and lining up right to the M&M's. The model we are trying to achieve is ambitious- but the potential gains in having a whole system approach to learning and the ability to cascade across BCUHB is worth the efforts in my opinion.
- There has been significant work around embedding the new Datix module. The aim is to have ALL mortality reviews are completed on this module – training throughout the Health Board has been distributed improve uptake. It is potentially the only 'paperless' review system in Wales and hopefully this functionality will improve engagement.

East local Clinical Effectiveness Group APRIL AND JUNE UPDATE
Medicine
- Dr Orod Osanlou, Consultant Physician, Site Innovation Lead, Acute Medicine, has been recognised for his tireless efforts for the biggest vaccine trial in Wales.

Surgery
- Elective Inpatient Orthopaedic Surgery – Inpatient activity restarted on the 17th February 2022.
- Roll Out of EPRO – EPRO is a digital dictation system which allows our admin teams to produce URGENT/SPECIFIC letters and eliminate typing delays.
- First Theatre Green meeting held 4/5/22. Working group to look at current practices, explore and implement change where possible for more sustainable alternatives to help reduce carbon footprint. First task is for larger shut down at night of scavenging, anaesthetic machines, monitors, surgical equipment and computers in all theatres (excluding Emergency and Maternity). (Consultant Anaesthetist Dr A Williams, Theatre Matron, Surgical Staff – Clinicians and Nursing).

Emergency Medicine
- Commencement of criteria led discharge competencies on AMU SS – training programme in place with consultant support and engagement.
- Recruitment – A number of senior ED nurses have been appointed, funded through the ED business case. First physician associate has started within ED, managing her own case load.

Other achievements
- We are pleased to announce that Mrs Geeta Kumar has been appointed to the post of National Clinical Lead for Planned Care Programme in Gynaecology in Wales.
- Human Factors Training – has gained speed. HF steering group is regularly attended by Geeta Kumar, representative for the East. There is a core HF

MDT group being identified for training. The group were asked to identify those member of staff who may be interested, especially within nursing and our allied professional group—work progressing rapidly with planned training by AQUA.

British Association for Cardiovascular Prevention and Rehabilitation (BACPR) Poster Presentation

- Poster presentation accepted by BACPR. Improving home exercise programme delivery and support for patients in Cardiac Rehabilitation. (Louise Cartwright – Exercise Physiologist)

Recruitment

- A number of senior Emergency Department (ED) nursing posts have been appointed to which were funded through the ED Business Case. Recruitment to remaining posts is ongoing. A second Physician Associate has been appointed, awaiting a start date. (ED Team)

Central CEG – APRIL UPDATE

- Recognition in December 2021 from Glyndwr University to Professor Hobson for his commitment and contributions towards research and education. Professor Hobson has been deeply involved in research surrounding Parkinson's disease and other movement disorders and neurocognitive disorders for several years. He has also played a crucial role in supporting the Movement Disorder Service in YGC clinically and educationally.

- A new Frailty service has commenced in YGC Emergency Quadrant on 9th Feb 2022 with Emergency Department Observation Unit (EDOU) as the footprint for the Frailty Unit. It is envisaged that the service will improve quality of care for older (≥ 75yrs) people with moderate frailty and co-morbidities offering Comprehensive Geriatric Assessment (CGA) and focussed rehabilitative interventions to reduce length of stay and facilitate prompter discharge with community support. Formal evaluation of the service will be undertaken in due course.

West Quality and Safety/ Clinical Effectiveness Group APRIL AND JUNE UPDATE

- Co-location of AMU services has been achieved.

Medical Education

- A pan-BCUHB medical education 'away day' was held in late 2021 with the whole medical education team invited. This work has co-produced a draft vision and strategy with a wide range of education leaders, management and administration colleagues. It has produced a list of priorities and this has formed the basis of continuing pan-BCUHB medical education team meetings and work.

- Advocate of Well-being and Safe-working appointed – this role is to provide a further avenue for support of doctors around their well-being, safe hours of working and psychological safety. It is not intended to replace existing governance frameworks in the Health Board.

- Health Board agreement to fund a 12 place new Physician Associate graduate programme. The PA Steering Group will set standards and oversee the quality of these placements with the intent of mirroring the Foundation Year programme for doctors and thus developing safe and supported PAs for permanent roles in the Health Board.

- Health Board agreement to fund a PA Programme Lead sitting in Med Ed to oversee the above and the BU student course to full employment.

- SEREN Project. Existing excellent work for this widening access programme between WG, Higher Education and the HB for school pupils has now been rolled out to all HB sites and now includes dentistry. Local teams have really worked inspirationally on this and should be congratulated.

- Bespoke courses for example IMPACT (medicine), Excellence in Surgical Supervision, Non-Operative Technical Skills, Transformative Medical Reflection, Acute Common Stem courses amongst others have been hosted and funded by medical education.

- Master's Level Medical Education module – 4th running of the course as part of our ongoing faculty development programme has meant further colleagues stepping forward for important medical education leadership roles and a real Community of Practice amongst the medical education team across the Health Board. Plus bespoke 2 day leadership course for all junior doctors leads across BCU to develop their skills, support them in their roles and also as a thank you for giving up their time.

- Specialty specific business meeting focusing on all domains of governance i.e. Quality, Safety and Clinical Effectiveness, Finance, Performance, Workforce, Health and Safety and Risk. Inaugural meeting with General Surgery in May with different specialty each week on 6-week rolling programme. Multidisciplinary team – Medical, Nursing and Ops with inclusion of linked/support services when required/requested. Positive feedback received from participants and fed back to site Directors.

JUNE MEETING

Clinical Law & Ethics Sub-Group (CLEG)

Since the last Alert, Assurance, Achievement report (AAA) to CEG in October 2021, the CLEG has met on the 18th January 2022 and 2nd May 2022. In these meetings the Group discussed:
- End of life decision making during the Covid-19 pandemic / related winter pressures
- Assisted Dying – key arguments used in the debate on physician-assisted dying

Drug & Therapeutics Sub-Group

Analysis of the BCUHB performance against the 2021-22 National Prescribing Indicators in quarter three indicated that, despite the ongoing pressures of the COVID-19 pandemic, there has been a 16.1% reduction in the number of patients with AF prescribed antiplatelet monotherapy. There has also been a continued reduction in the prescribing of hypnotics and anxiolytics, with a reduction of 7.22% seen versus quarter 3 in 2020-21. Inappropriate prescribing of hypnotics and anxiolytics may contribute to the problem of physical and psychological dependence and may be responsible for masking underlying depression. BCUHB also remains the best performing health board against the efficiency indicator looking at the prescribing of items of low value.

From the 1st March 2022, the Welsh Blood Service has been procuring normal immunoglobulin (IVIgG) on behalf of BCUHB. This coincides with the use of a new building on the Wrexham hospital site to host IVIgG supplies for the Health Board. Regular meetings with the Welsh Bloods Service and IVIgG manufacturers have provided reassurance of sufficient stock to meet our needs. Welsh Blood Supply provides a product selection guide listing the various brands of IVIgG available. This guide is hosted on the Prescribing Matters pages of the intranet to ensure information on supply availability is readily accessible.

In April there was a medicines transcribing and e-discharge (MTeD) software upgrade. The secondary care prescribing system now links closely to the INFORM formulary to help rationalise the choice of preparations offered, thereby reducing the likelihood of picking errors and encouraging selection of formulary approved products when prescribing.

Strategic Delivery Group for Palliative and End of Life Care (PEoLC)

Presentation of Retrospective Audit – Compliance of Completed DNACPR Forms with the All Wales Policy. This highlighted significant risks and therefore essential to consider and demonstrate learning.

Paediatric PEoLC Update – New paediatric palliative care consultant commenced in post at Ty Gobaith with north wales scope. Children's hospices in wales have received

an increase in funding from Welsh Government which will help to support increased reach. Additional funding grant secured for bereavement care also.

Update on NACEL Audit (National Audit of Care at the End of Life) – Round 4 to commence this summer until October 2022. Round three report due July 2022.

Report title:	BCUHB Vascular Quality Review Panel Chair's Assurance Report		
Report to:	Quality, Safety and Experience Committee (QSE)		
Date of Meeting:	Tuesday, 05 July 2022	Agenda Item number:	4.2
Executive Summary:	Chaired independently, a Vascular Quality Review Panel has been assembled to inform and provide any identified learning points and recommendations to Betsi Cadwaladr University Health Board (BCUHB) following findings from the Royal College of Surgeons (RCS) report '*Royal College of Surgeons' (RCS) Report on 44 clinical records relating to vascular surgery on behalf of Betsi Cadwaladr University Health Board Review visit carried out on 19 July 2021, report issued: 20 January 2022'*. This report provides an update on progress of the work with eight Panel meetings now having been held as of 15 June 2022 when this paper was produced.		
Recommendations:	QSE committee members are invited to receive and consider the progression of the work of the Panel.		
Executive Lead:	Dr Nick Lyons, Executive Director of Medicine		
Report Author:	Susan Aitkenhead, Independent Chair, Vascular Quality Review Panel		

Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒

Assurance level:	Significant ☐	Acceptable ☒	Partial ☐	No Assurance ☐
	High level of confidence/evidence in delivery of existing mechanisms / objectives	General confidence/evidence in delivery of existing mechanisms / objectives	Some confidence/evidence in delivery of existing mechanisms / objectives	No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:

The multi-professional Panel is working well collectively, and is on plan in relation to expected timescales.

Escalation of specific points identified, whether historical or aligned to a more current timeline, is taking place to feed in contemporaneously to the relevant improvement work being undertaken across the Health Board, rather than to delay until the final report. Therefore, relevant emerging points have been escalated after each Panel meeting, with an aim of reducing the likelihood of recurrence and helping to inform any required changes to practice.

Formal escalation is also undertaken, when from the information that is available, the Panel is unable to be assured of whether the necessary and appropriate follow up and aftercare plans were put in place for patients.

Please note the assurance level has not been graded as *significant*, due to the delay in the appointment of the external surgical expert; and the fact that the Panel is awaiting further clarity as to the most effective way that it will receive updates and assurance back of actions taken following escalations.

Link to Strategic Objective(s):	• Delivery of safe and effective services in partnership; • Stronger and aligned management and governance; • Engagement with staff, users and stakeholders;

Regulatory and legal implications	*Legal:* There is an obvious relationship to this Panel work, and the already established concept of redress and the duty placed on NHS Welsh bodies to consider whether harm has or may have been caused under the Putting Things Right (PTR) guidance and regulations. This therefore forms part of the collaborative working with the internal Vascular Quality Team which is also reviewing the clinical records in detail, complementary to the Panel review; and which also offers another dimension to triangulation and learning.

The Panel's comments help inform the PTR decision-making to avoid potential duplication and offer further expertise or opinion if required. The Acting Assistant Director of Patient Safety leads this part of the Panel's agenda in looking to identify any potential triggering of the Health Board's duty of redress under the PTR regulations should the occurrence of avoidable harm be identified.

Regulatory: Panel judgments are based on the information available to them with their assessments underpinned by an evidence base (relevant to that period of time), and their own professional knowledge and scope. The proforma being completed is mapped to Royal College of Physicians' documentation with accompanying guidance taken from the General Medical Council.

The Chair receives any declaration of interests or conflicts of interest at the start of each meeting.

Panel members have vicarious liability provided via their BCUHB contractual arrangements. Those Panel members who are professionally regulated also have a professional accountability as registrants on a professional register and are held to their own regulator's professional standards and guidance.

The Panel does not have a responsibility to determine whether they consider that a clinician has potentially breached any professional regulatory standards or question fitness to practise. Any identified concerns, should they be identified, regarding practice are to be escalated to the Executive Director |

	of Medicine as the SRO for this work. On commencement of this work, this escalation process was formally agreed by letter between the SRO and the independent Chair of the Panel.
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	Any risks identified by the Panel are escalated as per the agreed process to the Executive Director of Medicine as the SRO for this work. Risks are added to the Vascular Steering Group risk register as relevant. It is proposed that it is helpful for committee members to be aware of the following risks that were identified and have now been addressed: *One*: a specific risk for the work of the Panel has been the delay in appointing an external surgical vascular expert. A number of candidates were spoken to, but they were unable to commit to the timescales and amount of work to be undertaken. However, an appointment has now been made with the external expert taking up the agreed PAs in June 2022. To avoid any further delay, the Panel itself commenced work on the 6 April 2022. However, no cases are considered closed until the external surgeon has also reviewed and their findings will be then amalgamated with the Panel's other findings to provide a final review of each clinical record. *Two*: all cases are equally important and treated as such, however, there had to be some order of assessment agreed. Therefore, to mitigate risk, stratification of the order of review has been undertaken by allocating a considered red/amber/green status to the records mapped to the feedback from the RCS report. An additional 'red/red' allocation has been added to identify those records which were omitted from the review in July 2021 so that these records would be reviewed by the Panel first. It should be noted that this methodology is not an 'exact science', but has provided a systematic approach to the order of reviewing the 47 clinical records. Both the Panel, including the external non-medical expert, and the internal vascular quality team has agreed to the order of stratification. The external surgical expert is also to confirm that

	they are content with the order as it remains, as a final 'check and balance'.
Financial implications as a result of implementing the recommendations	On completion of this work of the Panel, a report will be presented to the Executive Director of Medicine, as SRO for this work. The report from the Panel will aim to ensure that recommendations are able to support any required levers for change and are composed to enable an effective response and lead to any improvements recommended being undertaken, embedded and sustained.
Workforce implications as a result of implementing the recommendations	On completion of this work of the Panel, a report will be presented to the Executive Director of Medicine, as SRO for this work. The report from the Panel will aim to ensure that recommendations are able to support any required levers for change and are composed to enable an effective response and lead to any improvements recommended being undertaken, embedded and sustained.
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	As noted above, relevant risks and/or issues identified by the Panel are escalated as per the agreed process to the Executive Director of Medicine as the SRO for this work. Risks are also added to the Vascular Steering Group risk register as required.
Reason for submission of report to confidential board (where relevant)	Concurrent work on the provision of vascular services across BCUHB consists of: 1. An urgent response as part of BCUHB's ongoing own checks and balances on the standards of quality and care in the service and continuing to build on and embed improvements which have already taken place or are in rapid train of identification. 2. 'Business as usual' in relation to delivery of care and the vascular improvement plan which is to ensure that vascular patients receive the most appropriate and timely care. 3. Any other relevant longer term local, regional or national transformational work occurring post-Covid, or as part of wider transformational policy initiatives. The work of the Panel sits within the short-term urgent response model (as noted above in 1.).
Next Steps: The work of the Panel continues as per the agreed methodology and Terms of Reference.	
List of Appendices: None	

QSE 05 July 2022 meeting
BCUHB Vascular Quality Review Panel Chair's Assurance Report

1. Background
1.1 Chaired independently, a Panel has been assembled following findings from the Royal College of Surgeons (RCS) report '*Royal College of Surgeons' (RCS) Report on 44 clinical records relating to vascular surgery on behalf of Betsi Cadwaladr University Health Board Review visit carried out on 19 July 2021, report issued: 20 January 2022*'.

1.2 The RCS January 2021 report stated that for a number of clinical records "the Health Board should review these comments, alongside the local information it holds, and determine if the patient records contain the information, they would expect for the patient episodes of care". There was also a recommendation that there should be scrutiny of whether the necessary and appropriate follow up and aftercare plans were put in place for a number of patients.

1.3 It should be noted that a total of 50 clinical records were originally agreed for review within the RCS terms of reference, however a number were subsequently not presented to the RCS review team. It has now been identified that within the additional numbers which were not submitted and the 44 which were, there were two duplicate records and two that did not exist, so clinical records belonging to 47 patients in total are to be reviewed as part of the Panel's structured case review.

    1.3.1 All cases are equally important and treated as such, however, there had to be some order of assessment agreed. Stratification of the order of review has therefore been undertaken by allocating a considered red/amber/green status to the records mapped to the feedback from the RCS report. An additional 'red/red' allocation has been added to identify those records which were omitted from the review in July 2021 so that these records would be reviewed by the Panel first. It should be noted that this methodology is not an 'exact science', but has provided a systematic approach to the order of reviewing the 47 clinical records. Both the Panel, including the external non-medical expert, and the internal vascular quality team has agreed to the order of stratification. The newly appointed external surgical expert is also to confirm that they are content with the order as it remains, as a final 'check and balance'.

1.4 From the information that is available to Panel members, and as per the Terms of Reference, when the Panel reviews the individual clinical records, the following points, are then considered for the relevant episodes of care being taken into account:

- Whether the patient records contain the information expected for the patient episodes of care;
- Were the necessary and appropriate follow up and aftercare plans put in place.

2. Meetings held and ways of working
2.1 The multi-professional Vascular Quality Review Panel continues to meet weekly and on the 15 June 2022 had now reviewed a running total of clinical records for nineteen patients over the course of eight meetings. It should be noted that the majority of these clinical records are large and complex due to the nature of the care being delivered and the additional co-morbidities often presented by the patients. The Panel's process of review, includes noting the dates of the episodes of care and consideration of relevant evidence base and

recommended or mandatory standards at that time; as well as any aligned potential consequences or implications related to the Covid pandemic.

2.2 There has been a delay in appointing to an external surgical vascular expert. A number of candidates were spoken to, but they were unable to commit to the timescales and amount of work to be undertaken. However, an appointment has now been made with the external expert taking up the agreed PAs in June 2022.

    2.2.1 To avoid any further delay, the multi-professional Panel minus the external surgical expert, but with a range of other medical and non-medical members, commenced work on the 6 April 2022. However, until this expert surgical practice part of the review has been completed and amalgamated with the Panel's other findings, no cases are considered closed from the Panel's perspective of the work that they have been charged to undertake.

2.3 The Panel can only make judgment on the information that is available to them and it should be noted that following the first couple of meetings it was recognised that it was difficult at times for the Panel to hear the patient voice from solely reviewing the clinical records as the information that was available. It was also agreed that it is vitally important as part of this work to understand what matters to patients individually. Therefore, it was proposed and then approved, that the BCUHB Patient and Carer Experience Lead, who is also a Panel member, would contact the patients whose records were being reviewed with an offer to enable them to provide any feedback which they may also want to be heard. The patients, or their Next of Kin, should they be sadly deceased, had also previously been contacted by letter to make them aware of the work of the Panel, prior to the work commencing.

    2.3.1 This offer and subsequent conversation, if taken up by the patient, is being undertaken under the usual parameters of the work of the BCUHB Patient and Carer Experience Lead. The Panel's Terms of Reference have also been updated in relation to this.

    2.3.2 A number of patients have now participated, and no one has declined the offer since this approach commenced.

    2.3.3 This work also sits alongside further work being undertaken by the Patient Experience Team, where they are working with the Vascular service to develop an annual plan of capturing patient experience.

    2.3.4 In the case of those patients who are sadly deceased, and whose Next of Kin had received the initial contact letters, it was initially agreed that further contact would not be made at that point, to avoid any potential further upset or anxiety. However, this was to be reviewed following the assessment of how many patients were positively responding to the opportunity to feedback, as to whether it may be helpful to extend it to those family members. Therefore, it was agreed at the May 2022 Vascular Steering Group (VSG) that this approach should also be extended to Next of Kin where those patients are sadly deceased, as patients were reporting that they were pleased to be a part of this process.

2.4 The Independent Chair, in order to understand more around the model and infrastructure of the vascular service, especially across all the different sites, has now visited two sites - Ysbyty Glan Clwyd and Ysbyty Maelor Wrexham - with the third visit to Ysbyty Gwynedd Bangor currently being planned.

3. Any emerging Panel findings

3.1 A caveat should be noted with this report in that the work of the Panel is still at an early stage so it is too premature to identify with confidence, specific themes or factors. However, from the information that is available to the Panel, there has been identification so far, of improvements required that are principally related to standards of documentation, communication, some aspects of consent and wider shared decision-making with patients, alongside a need for demonstrating and recording when effective multi-disciplinary team working (MDT) is taking place. Concerns have been raised as to the poor physical condition of the paper records themselves, and assistance from the medical records department is now being provided to the Panel in relation to this.

3.1.1 The Panel agreed that those specific points identified, whether they are historical or aligned to a more current timeline, are helpful to feed in contemporaneously to the relevant improvement work being undertaken across the Health Board, rather than to delay until the final report. Therefore, relevant emerging points have been escalated after each Panel meeting, with an aim of reducing the likelihood of recurrence and helping to inform any required changes to practice.

3.1.2 The recurrence of the identification of any issues identified in previous records also continue to be escalated, even if they are repetitive, to help with quantification of any potential risk.

3.2 Formal escalation is also undertaken, when from the information that is available to them, the Panel is unable to be assured of whether the necessary and appropriate follow up and aftercare plans were put in place for patients.

3.3 The Panel has also agreed that when they reach around the mid-point of reviewing the 47 clinical records which they are currently charged with examining, they will additionally map out their findings to that point, against the '*Royal College of Surgeons (RCS) Report on the Vascular Surgery Service Betsi Cadwaladr University Health Board Review visit carried out on: 11- 13 January 2021 and Report issued: 15th March 2021*'.

3.3.1 This RCS March 2021 report reviewed the service more broadly and the Panel proposes that this will then provide an opportunity to start to triangulate their findings against both of the RCS reviews (March 2021 and January 2022). This will aim to potentially offer a wider more holistic update, although again with a caveat that this will only be mid-way through the Panel's work, and as always, from the information that is available to them.

3.3.2 It is also suggested that an interim external report would be helpful, at this mid-term point to provide an external update and assurance on process and timescales.

3.4 It should also be noted that the final Panel report will also incorporate the identification of good practice, and certain elements of this are continuing to be identified in the reviews at times as well as some of the points for improvement.

4. Ensuring a Panel assurance loop
4.1 A final report from the Panel will aim to ensure that recommendations are able to support any required levers for change and are composed to enable an effective response and lead to any improvements recommended being undertaken, embedded and sustained.

4.2 Terms of Reference also set out that should the Panel identify any immediate serious concerns in relation to ongoing or potential risk these will be escalated immediately by the Panel's Chair to the Executive Medical Director, as SRO.

4.3   Escalations principally take two forms.

    4.3.1   One in the form of patient identifiable data in relation to whether from the information available to the Panel, they are unable to be assured of the necessary and appropriate follow up and aftercare plans having been put in place for the patients whose clinical records are included within the review. If there is identification of a lack of assurance, then this is currently escalated to the Executive Director of Medicine as SRO.

    4.3.2   The second escalation process is the broader identification of points which may be possibly grouped under potentially emerging themes, such as documentation, consent, policies etc. Again this is currently escalated to the Executive Director of Medicine as SRO.

4.4   A meeting was held between the independent Chair of the Panel, the Executive Medical Director, and the interim Board Secretary to discuss the most effective way to provide update and assurance back to the Panel of actions taken following the submission of any 'escalations', and any that may sit within the future final report.

4.5   Assurance back to the Panel has been provided so far, in an update that a multi-professional Documentation Task and Finish Group is being set up and to be chaired by the Executive Director of Medicine. This is to include each of the clinical executives as well as the Chief Digital and information Executive and will focus not only on the vascular notes but on wider note keeping across the Health Board.

    4.5.1   Information has also been provided that a review of ward accreditation is also to take place to ensure greater assurance on the points raised.

    4.5.2   Additionally, an escalation from the Panel in relation to them agreeing that they were not able to be fully assured of the necessary follow up having been put in place for a patient whose records were reviewed, was promptly passed on to the relevant senior management team from the Executive Director of Medicine as SRO.

4.6   Moving forward the interim Board secretary is considering the most appropriate governance mechanism to provide full and robust assurance, and which is aligned to other work that the Board Secretary's team is undertaking on refining the detailed aspect of assurance reporting. She is due to discuss this again with the independent Chair of the Panel. Again, the Terms of Reference will be updated to reflect this when it is agreed and an update will be provided to this committee, and the VSG.

4.7   Additionally, the independent Chair of the Panel has met with the Vascular Network Director to ensure that the relevant Panel escalations are also fed into the Vascular Implementation Plan, and the Panel assurance loop is then also strengthened via this operational work.

5.   Budgetary/Financial Implications
5.1   There are no budgetary implications associated with this specific paper. Resources for maintaining compliance oversight are overseen by the Acting Associate Director of Quality, on behalf of the Executive Director of Medicine as executive SRO for this work.

6.   Risk Management
6.1   Any risks aligned to the work of the Panel, or its' findings are to be included within the risk register of the Vascular Steering Group. When the independent Chair of the Vascular Quality

Review Panel met with the Vascular Network Director, they also discussed this and how any risks and/or issues are added as relevant. A regular meeting is in the diary to ensure that any read across or findings from the work of the Panel is fed as relevant into the operational work, to prevent any unnecessary delay to current improvement work as set out above in paragraph 3.1.1.

6.2   As noted previously, two risks were identified and have now been addressed and mitigated. These are set out above within the cover sheet to this paper, and in paragraphs 1.3.1, 2.2 and 2.2.1 and refer to the delay in appointing to an external surgical vascular expert; and, stratification of the order of review of the clinical records.

7. Equality and Diversity Implications
7.1   In determining whether care was of an acceptable quality, the Panel collectively brings a number of separate skills, experience, competencies and understanding. This also includes ensuring the safeguarding of vulnerable populations; and considering all aspects of equality and diversity.

7.2   The ability for the Panel to clearly hear the patient's voice is also a key and helpful part of considering any equality and diversity implications, and to be assured that individual respect and dignity is central to the delivery of all care.

7.3   Additionally, it is well recognised that when things go wrong, there is a need to make sure that lessons are learnt, and improvements are made and embedded. All staff should be confident in their position, no matter their role, or where they work, that they always feel that they are able to speak up. Whether it is about something that does not feel right, usually around an impact on patient safety or quality, but may also include wider issues, or suggestions for improvement. The Panel will consider within their findings whether there were any possible opportunities to strengthen this as a central tenet to BCUHB working as part of the final recommendations of this work.

8.   Summary
8.1   The work of the Panel continues as per the agreed methodology. QSE committee members are invited to receive and consider the progression of the work of the Panel.

[END]

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient and Carer Experience Group
Chair of meeting or lead for report	Carolyn Owen, Acting Assistant Director of Patient and Carer Experience – Chair (on behalf of Mandy Jones, Acting Deputy Executive Director of Nursing – Chair)
Date of meeting	21 April 2022
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	05 July 2022
Presented by	Matthew Joyes, Acting Associate Director of Quality

---

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

Division reports:
- Recruitment: Highlighted staff shortages across the HB
- Increase in complaints: common themes: Communication, access to appointments

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

- **Patient Story**: Nicola's story – sharing her experience of when her father was an inpatient in YGC, when discharged her father went home without a number of personal items, which is very upsetting, this is an issue across the HB. Following discussions the Patient Liaison Officers are linking with group members to look at possible initiatives eg 'yellow box' and or digital tracking of lost items.

- **Bereavement Quality sub Group**: Model specification in final draft out for consultation, all HB's in Wales will have a lot of responsibility to ensure provide equitable access to the right level and type in conjunction with the bereavement care model. The Framework provides a focus /plan on moving forward. Meeting arranged with Gill Harris to discuss the funding for Bereavement Nurses.

- **Patient Communication and Readers Panels Sub-group**: HB have a duty to provide quality information to patients and public. Any leaflets produced by the HB (not EIDO owned) follow a process, they are submitted to a panel who meet monthly to review. At

the moment working on 28 leaflets received from Wrexham ED dept. once approved will share across the HB.

- **Report on Catering Services delivery of in-patient:** The HB are fully compliant with Natasha's Law and allergen regulations of the Food Safety Act. BCU work to the Primary Authority agreement, a contract with public protection dept. and are the only HB that use Primary Authority it's normally organisations such as Supermarkets. All allergen information is available across the HB for people to use as required.

- **NICE Guideline status compliance report:** Baseline Assessment Standard QS15 completed, overall partially met compliance, working on some areas need to improve on.

- **Carers update:** Since the last meeting captured 6 Carer focussed story's. Linking with NEWCIS and Carers Outreach who have contracts for Hospital and GP Facilitators and help support carers. Working with them to increase the number of carer referrals they receive by 30% during this financial year. Attend a ward once a week at a particular time to support staff and capture referrals.

- **West Acute:** Health Improvement action plan report released this week, significant amount of work undertaken in relation to the actions eg Discharge checklist, pain management, observations around patients deteriorating. Meeting held around quality assurance, now have a robust assurance in place around issues identified and being closely monitored via Hospital Management Team (HMT).

- **Cancer Services:** developed an in-depth improvement plan for Oncology patients who are admitted mainly out of hours. Reviewed the patient journey from the very start and looked at holistically, developed a robust action plan to undertake improvements from the start of a cancer patient's journey.

- **West Area:** productive PTR meetings taking place. Noted 50% of complaints are related to Primary Care. New Practice Managers in place, Primary Care team linking closely with them.

- **Central Area:** obtaining more proactive views from services, linking with PALS team to gain more rich information of what services user want from our services.

- **East Area:** Pressure Ulcers (PU) – non service acquired patients admitted to District Nursing Service with pre-existing PU, account for a large number of Incidents. Joint working with GP's around preventative management and treatment of patients. Complaints increased since April 2021. Over 50% of complaints profile relate to Primary Care. Covid restrictions regarding visiting continues to feature in complaints. Proactively working with nursing staff to ensure plan, prepare and anticipate patient's needs.

- **Womens Services:** Main critical issue for escalation is the significant delay in receiving post mortem and histology results following pregnancy loss at any gestation, taking up to 6 months and longer. This causes significant stress for family's awaiting results and also many of these women want to become pregnant again and are having to delay doing so because worried what the post mortem result will show and if anything significant that may impact on a subsequent pregnancy. This has been highlighted to senior

management team and being looked at on an all Wales basis. There is a shortage of paediatric pathologists only one in the whole of Wales. This has been highlighted across Wales and is something we have to manage. We are in constant contact with families to keep them informed.

- **Mental Health :**
  Two Alerts: 1. Complaints performance deteriorated, now have 10 overdue complaints more to do with the complexity of authorising the responses. **2.** One overdue reportable investigation, awaiting permission to investigate from Merseyside Police.
  Themes: Telephone – improve systems, share learning and Communication on discharge and generally for in patients
  Two High Level risks: 1. Environmental improvements made to reduce ligature risks. **2.** Managers support and presence in the ABI service – seconded a senior manager into the ABI service

- **Item Approved:** Patient and Carer Experience report : December 2021 – March 2022

2   **Achievement** – include any significant achievements and outcomes

- **All Divisions:** praised the work of the PALS Team throughout the meeting, highlighted support received and working together on a regular basis, also sharing information.

- **Cancer Services**: Beryl Roberts-Head Of Nursing, Cancer Services recently retired has been given the bronze award for Oncology Nurse of the year.

- **East Area:** MILENKO system now operational in East Area, managing staff from a workplace point of view, see more patients and provide a more meaningful consultation.

- Rachel Wright, Lead Patient Experience and Carers Service, invited to present on behalf of BCUHB the Long COVID Lived Experience work at the Improvement Cymru Conference.

Chair's Report

Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or area reporting in	Patient Safety and Quality Group
Chair of meeting or lead for report	Mandy Jones, Acting Deputy Executive Director of Nursing – Chair (on behallf of Gaynor Thomason, Interim Executive Director of Nursing and Midwifery)
Date of meeting	9th May 2022
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	5th July 2022
Presented by	Gaynor Thomason, Interim Executive Director of Nursing and Midwifery

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

Patient Story – Heart Failure

➢ This project was presented by Vikki Jenkins who explained a pilot is currently running with regards to the use of remote patient monitoring (RPM) technology to help proactively manage heart failure patients in their own home

➢ Patrick Hill and Mandy Jones gave thanks to all the team involved with this project and advised that they can see the potential benefits of this going forward.

Staff Vacancies

➢ It was noted that there are a vast amount of vacancies across numerous departments and due to the lack of interest being received; it is causing significant problems across the health board.

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

Infection Control Sub-Group:

➢ Rebecca Gerrard advised that we had retained 1st position for the CDF, so we now have the lowest rates across the health boards

Personal Protective Equipment:

➢ Christopher Shirley gave feedback from the latest PPE Steering Group Meeting, advising that the current strains seem to be almost exclusively transmitted through the aerosol route. The other factors are much less of a transmission risk and we are just awaiting on that final guidance from the Resource Council. Was advised that a 1st responder should not delay CPR and to don full PPE

Safer Medication Steering Group:

➢ Judith Green updated in relation to the filter needle situation - several problems over the last few months where people were reporting colouring with certain antibiotics. It was apparent that this was not just for BCUHB it was happening across Wales and the UK. Patient safety team actioned the alert.

➢ Judith advised that safety notices are in hand and should be signed off PSN 60 in the next month

➢ Judith advised that East are very good with presenting their education harm reviews

Datix Implementation / Quality Systems Management Group:

➢ Matt Joyes advised that we are aware of the problems that colleagues across all sites are having with the Datix system and the frustrations it is creating. We are actively working with the Central IT team to resolve these issues. This is a national system that is being used throughout Wales and not an in house system. Matt asked if all colleagues could bear with us at this time while we try to work through these.

➢ Kath Clarke advised that one of the biggest concerns was accessing the system. A message would appear advising the member of staff that they need to contact admin. IT central have agreed to work with our IT colleagues to work through resolving these issues. In the interim, staff can access the system via the Betsi Net, which seems to be working.

Falls:

➢ Mandy Jones advised that there had been an improvement over falls over the last 12 months. A HSE notice had been issued for manual handling and falls and an Improvement plan is being implemented with support by the health and safety team

➢ Mandy advised that there are currently low numbers with regards to the mandatory training for falls. Staff will be made aware of the importance of this training being completed

Safeguarding:

➢ Michelle Denwood advised that it is currently a tier 1 risk and safeguarding now reports into the Mental Health Act Compliance Consent Committee not QSE.

- Michelle advised that the LPS implementation is the 14th June, currently going through consultation, looking at code of practice; we all need to recognise the significate impact on front line working

- Michelle advised that our two independent hospital based independent domestic violence advisors are now in place

Secondary Care:

- Mandy Jones advised that there has been an internal review of theatres at Wrexham and concern has been presented regarding the Fleming Ward, an action has been put forward to look at reducing beds.

Central Area:

- Sharon Comrie advised that there has been issues with safety notices so a SOP has been developed

- Sharon advised that we have one inquest situation with the Regulation 28 notice from the coroner in relation to our processes for review of changes to medicines for care home residents. All information is being collated and is due June 9th

East Area:

- Richard Waterson advised that we have had three safety alerts this month which we are currently working through and looking at how we engage with the families

- Richard advised that there has been a deterioration around GP appointments, and an improved booking system is currently being put into place

Womens Services:

- Maria Atkin advised that there were concerns around the Countess of Chester, however a partnership assurance meeting now takes place between the Health Board and the Chester and an assurance report has now been received

Mental Health and Learning Disabilities:

- Mike Smith advised that we have now started seven-minute briefings, which are currently being held when there is a significant incident and all areas of the mental health teams are involved so that we can rapidly share the significant learning.

Covid 19 Update:

- Carolyn Owen advised that we are currently aligned with the prison service, which means we can share good practice.

- Carolyn advised that we are looking at formulating a two-year plan; next stage will be the open and transparent information that we should have with relatives

Training Accommodation Resus Service Update:

➢ Christopher Shirley advised that central is the biggest area of concern, training is at 21%, new-born training is at 0% and currently working on action plans on all sites and will be supporting them with travel etc. Christopher advised that it is a significant risk and the execs are aware. Feedback should be given back in the next few days

3. Achievement – include any significant achievements and outcomes

Safer Medication Steering Group:

➢ Judith Green advised Gareth Hutchinson has won the Association of Pharmacy Technicians UK technician of the year award for the UK. We are all very proud of this achievement

Central Area:

➢ Sharon Comrie advised that they had won silver and bronze award for CAMHS and patient areas