

Bundle Quality, Safety & Experience Committee 11 January 2022

- 1 OPENING BUSINESS
- 1.1 09:30 - QS22/01 Patient Story : Gill Harris
Please review the video associated with this item off line
QS22.01 -FINAL IPC Story.docx
- 1.2 09:35 - QS22/02 Apologies for Absence
Apologies received from Nick Lyons
- 1.3 09:36 - QS22/03 Declarations of Interest
- 1.4 09:37 - QS22/04 Minutes of Previous Meeting Held in Public on 2.11.21 for Accuracy
QS22.04 - Minutes QSE 2.11.21 Public V0.2LR.docx
- 1.5 09:42 - QS22/05 Matters Arising and Table of Actions
QS22.05 - FINAL Summary Action Log QSE Public.docx
- 1.6 09:52 - QS22/06 Report of the Chair - Lucy Reid - FOR CONSENT
QS22.06 - Chair's Assurance Report QSE 2.11.21 v1.0.docx
- 1.7 09:57 - QS22/07 Report of the Lead Executive - Gill Harris - VERBAL UPDATE
- 2 STRATEGIC ITEMS FOR DECISION - THE FUTURE
- 2.1 DEVELOPING NEW STRATEGIES OR PLANS
- 2.1.1 10:02 - QS22/08 Clinical Services Strategy - Conrad Wareham - VERBAL UPDATE
- 3 QUALITY SAFETY AND PERFORMANCE - TO CONSIDER
- 3.1 10:12 - QS22/09 Covid19 Update - Gill Harris - TO CONSIDER
QS22.9 Vaccination Programme Gold Command Report 10.01.22 shared at QSE.pptx
- 3.2 10:22 - QS22/10 Corporate Risk Register - Simon Evans-Evans - FOR DISCUSSION
QS22.10 - QSE - CRR Cover Sheet V0.2-Draft.docx
QS22.10a - Appendix 1 - CRR Report for QSE.pdf
QS22.10b - Appendix 2 - Full List Corporate Risks.pdf
QS22.10c - Appendix 3 - Risk Key Field Guidance V2-Final.pdf
- 3.4 10:32 - QS22/11 Quality & Performance Report - Sue Hill - FOR CONSENT
QS22.11 - Coversheet QSE - January 2022 (November Position) Cymraeg DRAFT v0.1.docx
QS22.11 - Coversheet QSE - January 2022 (November Position) English DRAFT v0.1.docx
QS22.11a - QP Report QSE - January 2022 (November Position) FINAL.pdf
- 3.5 10:37 - QS22/12 Patient Safety Report - Gill Harris - FOR CONSENT
QS22.12 - FINAL Patient Safety Report CO amend.docx
- 3.6 10:42 - QS22/13 Quality/Safety Awards and Achievements : Gill Harris - FOR INFORMATION
QS22.13 - Quality Awards Paper OCT NOV 2021.docx
- 3.7 10:43 - QS22/14 Hergest HIW Report and Action Plan - FOR CONSENT
QS22.14 - FINAL HIW Hergest.docx
QS22.14 - FINAL HIW Report Appendix.pdf
- 3.7.1 10:45 - Comfort Break
- 3.8 10:55 - QS22/15 Vascular Services : Conrad Wareham - TO CONSIDER
QS22.15a - Vascular Improvement Plan 30 December 2021.xlsx
QS22.15 - Vascular Services.docx
- 3.9 11:10 - QS22/16 Safeguarding Q1/2 Report - Gill Harris - FOR CONSENT
QS22.16 - Final Version Corporate Safeguarding Six Month Exec Summary Report V1.00 (002) (003).docx
QS22.16a - Final Version Corporate Safeguarding Six Month Exec Summary Report Appendix 1 V1.00.docx
- 3.10 11:15 - QS22/17 Learning from Morfa Ward (Llandudno) - Gill Harris - TO CONSIDER
QS22.17 - FINAL LLGH - Cover Paper.docx

- QS22.17a - FINAL LLGH - Action Plan.docx
- 3.10.1 11:35 - QS22/18 Learning from Medication Incidents - Berwyn Owyn - FOR CONSENT
QS22.18 - QSE PMM medicine related harm version 10.docx
QS22.18a - Powerpoint template medication incident reporting v2.pptx
- 3.11 11:40 - QS22/19 Health and Safety - Sue Green - FOR CONSENT
QS22.19 - 2021_12_29 Q1 and Q2 2021 22 Health and Safety Report-final_SG.docx
QS22.19a - snapshot q1 2021.pdf
QS22.19b snapshot q2 2021.pdf
- 3.12 11:45 - QS22/20 General Surgery - Ysbyty Glan Clwyd - Conrad Wareham - TO CONSIDER
QS22.20 - General Surgery YGC Jan 22 (002).docx
- 3.13 12:05 - Lunch break
- 4 LEARNING FROM THE PAST
- 4.1 12:35 - QS22/21 Quality Governance Self Assessment Action Plan (Maternity Services) - Gill Harris - FOR CONSENT
QS22.21 - FINAL Quality Governance Self-assessment Update.docx
- 4.2 12:37 - QS22/22 Internal Audit report into HASCAS - Gill Harris - FOR CONSENT
QS22.22 - QSE coversheet HASCAS & Ockenden IA report.docx
QS22.22a - Briefing Paper HASCAS 14&15.pdf
- 5 CHAIR'S ASSURANCE REPORTS - FOR CONSENT
- 5.1 12:42 - QS22/23 Chair's Reports from Strategic and Tactical Delivery Groups - FOR CONSENT
QS22/23a - Patient Safety Quality Group - Gill Harris
QS22/23b - Strategic Occupational Health and Safety Group - Sue Green
QS22/23c - Patient and Carer Experience Group - Gill Harris
QS22.23a - FINAL PSQ Chair Report.doc
QS22.23b - Triple A Report SOHS Group held 02.11.21_Final_SG.docx
QS22.23c - FINAL PCE Chair Report.doc
- 6 POLICY MATTERS - FOR CONSENT
- 6.2 12:47 - QS22/24 Nurse Staffing Levels Policy ammendments - FOR CONSENT
QS22.24 - QSE cover sheet - Nurse Staffing Levels Policy ammendments Dec 2021.docx
QS22.24a - NU03 Nurse Staffing Level Policy Dec 2021.docx
QS22.24b - Nurse Staffing Levels Policy Appendices One - Nine.docx
QS22.24c - Equality Impact Assessment NSL updated 19.10.21.docx
- 7 12:49 - CLOSING BUSINESS
- 7.1 12:59 - QS22/25 Issues Discussed in Previous Private Session
Report into Mortality Post Bowel Cancer
- 7.2 QS22/26 Documents Circulated to Members
- 7.3 13:04 - QS22/27 Agree Items for Chair's Assurance Report to Board
- 7.4 13:06 - QS22/28 Review of risks highlighted in the meeting for referral to Risk Management Group
- 7.5 QS22/29 Review of Meeting Effectiveness
- 7.6 QS22/30 Date of Next Meeting
1.3.22
- 7.7 QS22/31 Exclusion of Press and Public
Resolution to Exclude the Press and Public - "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960."

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	IPC Story						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris (Executive Director, Nursing and Midwifery/Deputy CEO)						
Awdur yr Adroddiad Report Author:	Information taken from the Safe Clean Care intranet						
Craffu blaenorol: Prior Scrutiny:	Gill Harris (Executive Director, Nursing and Midwifery/Deputy CEO)						
Atodiadau Appendices:	N/A						
Argymhelliad / Recommendation:							
The Committee is asked to receive and reflect upon the patient story.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>Two videos have been produced to explain the work done to allow more visitors to attend our inpatient wards safely supported by lateral flow testing. The videos available on the intranet are:</p> <p>Sara Hardy, Senior Ward Sister at Alaw Ward in WMH, discuss the introduction of LFT in Cancer Services</p> <p>Lorraine Gardner: introducing LFTs in maternity services</p>							
Cefndir / Background:							
<p>Betsi Cadwaladr University Health Board is working to allow more visitors to attend our inpatient wards safely – supported by lateral flow testing.</p> <p>Our new approach will enable more wards to allow safe visiting wherever possible. It will require patients' loved ones, families and all other visitors to inpatient areas to keep to prearranged appointments, produce proof of a recent negative lateral flow result, and complete a screening questionnaire - including temperature check - ahead of entry.</p>							

A [template policy document](#) to support this change in visiting arrangements has been approved and is now available for use by all departments.

Patients attending clinics or outpatients appointments will not be required to submit a negative LFT result, but must continue to wear a mask, stay distanced and respect other COVID-19 guidance.

Visitors to a limited number of departments have been permitted in recent months, but only by appointment and only on production of proof of a recent negative lateral flow test. The success of this approach gives us confidence to extend these arrangements to more of our services.

Pilot schemes have been completed in maternity, cancer, children's and some mental health services.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.



Quality, Safety and Experience (QSE) Committee
DRAFT Minutes of the Meeting Held in public on 2.11.21 via Teams

Present:

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

In Attendance:

Jackie Allen	Chair of Community Health Council (CHC) (<i>part meeting</i>)
Reena Cartmell	Associate Director of Nursing (<i>part meeting</i>)
Jane Christmas	Interim Head of Clinical Effectiveness (<i>observing</i>)
Michelle Denwood	Associate Director Safeguarding (<i>part meeting</i>)
Kate Dunn	Head of Corporate Affairs (<i>for minutes</i>)
Gareth Evans	Chair of Healthcare Professional Forum (<i>part meeting</i>)
Simon Evans-Evans	Interim Director of Governance
Liz Fletcher	Assistant Area Director Children's (<i>part meeting</i>)
Sue Green	Executive Director of Workforce and Organisational Development (OD) (<i>part meeting</i>)
Alison Griffiths	Director of Nursing (<i>part meeting</i>)
Gill Harris	Executive Director of Nursing and Midwifery / Deputy Chief Executive
Sue Hill	Executive Director of Finance
Gavin Halligan-Davis	Interim Director of Performance (Designate) (<i>part meeting</i>)
Matthew Joyes	Acting Associate Director of Quality Assurance
Amy Kerti	Nurse Consultant : Dementia (<i>part meeting</i>)
Nick Lyons	Executive Medical Director
Melanie Maxwell	Senior Associate Medical Director/Improvement Cymru Clinical Lead (<i>part meeting</i>)
Sally Morris	Vascular Implementation Plan Adviser (<i>part meeting</i>)
Teresa Owen	Executive Director of Public Health
Katie Sargent	Assistant Director Corporate Communications and Public Engagement
Anne Stewart	(<i>observing</i>)
John Stewart	Service User (<i>part meeting</i>)
Chris Stockport	Service User (<i>part meeting</i>)
Adrian Thomas	Executive Director Primary Care and Community Services
Kamala Williams	Executive Director Therapies and Health Sciences
Tracey Williamson	Acting Director of Performance (<i>part meeting</i>)
	Nurse Consultant : Dementia (<i>part meeting</i>)

Agenda Item Discussed	Action By
It was noted that the meeting was being recorded in Teams for administrative purposes.	
QS21/160 Patient Story	

<p>QS21/160.1 An audio version of “Elizabeth’s vascular story” was played for members. The Acting Associate Director of Quality Assurance highlighted the key themes arising from the story in terms of the importance of recognising patients’ anxieties whilst in a hospital setting, and the provision of joined up care. He confirmed that the story had been shared with the service and would be helpfully used as part of training team members.</p> <p>QS21/160.2 An Independent Member queried whether the tissue removal procedure that had been undertaken in a ward setting had been appropriate in terms of maintaining patient dignity and whether this was a normal occurrence. The Executive Medical Director responded that this had been debated and challenged at the Vascular Steering Group and an action had been taken away to identify whether this is common practice or a one off. The Chair asked the Committee to be sighted on the outcome of these discussions. An Independent Member suggested that although this was a positive story, when presented to the Health Board on the 18th November officers would need to be ready to respond to criticisms that this patient had had to wait two years for treatment, and that it would be important to focus on the learning from the story. The Executive Medical Director acknowledged that there were delays in getting the patient onto the vascular pathway but that this would have been exacerbated by wider waiting list challenges. The Chair welcomed the patient story and was pleased to learn of the good outcome for the patient concerned but she agreed that the Board should reflect on the wider issues including the impact of the long wait.</p> <p>QS21/160.3 It was resolved that the Committee receive and reflect upon the patient story.</p>	NL
<p>QS21/161 Apologies for Absence</p> <p>QS21/161.1 Apologies had been received for Dave Harries and Louise Brereton</p>	
<p>QS21/162 Declarations of Interest</p> <p>QS21/162.2 None declared.</p>	
<p>QS21/163 Minutes of Previous Meeting Held in Public on 7.9.21 for Accuracy</p> <p>QS21/163.1 The minutes were agreed as an accurate record.</p>	
<p>QS21/164 Matters Arising and Table of Actions</p> <p>QS21/164.1 Updates were provided to the summary action log.</p>	
<p>QS21/165 Report of the Chair</p>	

<p>QS21/165.1 The Chair reported that:</p> <ul style="list-style-type: none"> • No Committee Chair's actions had been undertaken since the last meeting. • The two key areas of relevance to the QSE Committee that were discussed at the recent Health Board meeting were the support to the commissioning of an independent review into urology services, and the vascular services report. • Following the changes to Committee terms of reference she would wish to see Nurse Staffing reports (including for the Mental Health and Learning Disabilities Division) being transferred to the Partnerships, People and Population Health (PPPH) Committee's cycle of business on the basis this was the Committee with responsibility for workforce/people. The Committee were supportive of this proposal with a caveat that PPPH Committee would refer on any significant safety issues to QSE and financial issues to the Performance, Finance and Information Governance (PFIG) Committee. 	
<p>QS21/166 Report of the Lead Executive</p> <p>QS21/166.1 The Executive Director of Nursing and Midwifery reported that:</p> <ul style="list-style-type: none"> • A number of serious incidents had been reported up to Welsh Government (WG) including two never events which were linked to the use of the World Health Organisation checklist which Clinical Executives were working to systematically address. • Rapid learning had been undertaken for the most recent incident within ophthalmology and it was apparent that three immediate actions from acute sites had not translated across to services on the Abergele site; this was being addressed urgently. • Independent investigations were ongoing for a number of serious incidents including a homicide, a death by suicide at the Hergest Unit and an unexpected death at Ty Llewelyn. A first draft of the external review at the Hergest Unit had been received but had not yet been checked for factual accuracy. • Two recent public interest reports from the Ombudsman had been shared formally with the QSE Committee. • A Regulation 28 notice had been received. • A range of Healthcare Inspectorate Wales (HIW) inspections had taken place including an unannounced visit to the Hergest Unit. • A Patient Carer Experience champion in Mold Community Hospital had been presented with a gold award, and the Learning Disability Service had won a nursing category award from the Nursing Times. 	
<p>QS21/167 Quality Strategy Interim Priorities</p> <p>QS21/167.1 The Executive Director of Nursing and Midwifery presented the paper and highlighted the approach for developing the Quality Strategy given the context of a number of other strategies also being developed alongside it. The paper set out a range of interim aspirational goals that had been tested against the principles of providing safe, clinically effective healthcare and ensuring patients and carers were at the heart of</p>	

<p>services. The Acting Associate Director of Quality Assurance added that the engagement element of the Quality Strategy would be brought forward into the new financial year.</p> <p>QS21/167.2 An Independent Member suggested that the narrative wasn't particularly reflective of primary or community care and it was agreed this would be refreshed and made more explicitly. The Chair commented on the reference to learning from excellence and felt that the organisation should in fact be learning from when things went wrong to ensure consistent improvement. The Chief Executive accepted that the organisation should learn from excellence, from patient experiences and from clinical outcomes. The Executive Director of Public Health commented that the quality element of working in partnership to provide services could also be more explicitly set out in the paper.</p> <p>QS21/167.3 The Acting Associate Director of Quality Assurance undertook to take on board all the comments made, and members were invited to send any further comments to him as soon as possible. He wished to reassure the Committee that subsequent to the interim priorities the new strategy would be supporting a learning culture and that in taking a longer term approach it would mean the Quality Strategy could be much better aligned with Living Healthier Staying Well and the transformation agenda. It was agreed that the final revised interim priorities would be circulated to members.</p> <p>QS21/167.34 It was resolved that the Committee note the report and approve the interim quality priorities – subject to inclusion of suggested revisions.</p> <p><i>[Sue Green left the meeting]</i></p>	MJ
<p>QS21/168 Implementation of New Liberty Protection Safeguards</p> <p>QS21/168.1 Michelle Denwood joined the meeting and presented the paper which set out the current position in terms of the Board's readiness to implement the new Liberty Protection Safeguards (LPS). She highlighted this was a significant change in legislation led centrally and that the code of practice was still awaited. In terms of Deprivation of Liberty Safeguards (DoLS) activity, BCUHB had seen a 44% increase in applications with a further increase expected and additional challenges due to the complexities involved. It was reported that BCUHB was as prepared as possible for the new legislation and that a plan had been drafted for implementation. In addition an interim post had been identified to manage the implementation, but the success would also rely on clinical and organisation-wide buy in.</p> <p>QS21/168.2 An Independent Member asked whether appropriate training would be delivered within the required time frame and that the staffing complement would be sufficient. It was reported that Social Care Wales were hopeful in terms of the training delivery and that a business case was being developed for additional capacity. In response to a question from the Chief Executive, the Associate Director for Safeguarding confirmed there would be easy-read and bilingual versions of the patient literature. The</p>	

<p>Chair suggested that the LPS training may provide an opportunity improve DOLS quality, and the Associate Director for Safeguarding acknowledged that this should be the case and that a positive outcome of LPS should be that the assessment of capacity is undertaken at the point of admission or accessing of services rather than at the in-patient stage as is for DOLS.</p> <p>QS21/168.3 It was resolved that the Committee:</p> <ol style="list-style-type: none"> 1. Accept the position report in preparation for the implementation of LPS on the 1st April 2022. 2. Note the progress made and actions to be taken in relation to the implementation of the LPS within BCUHB. 	
<p>QS21/169 Nurse Staffing Levels (Wales): Adult Acute Medical And Surgical Inpatient wards and Paediatrics <i>[Alison Griffiths joined the meeting]</i></p> <p>QS21/169.1 The Executive Director of Nursing and Midwifery introduced the agenda item and highlighted that an implementation plan had been developed in readiness for the extension of the Act to include paediatrics, and secondly that the Act had been applied across all BCUHB's acute services and it was acknowledged there was further work to be done in areas of higher acuity.</p> <p>QS21/169.2 The Director of Nursing then went onto present the paper, highlighting that it was a very detailed report but that the issues for consideration were set out in the recommendations. She noted that the annual paper to the Health Board each May underpinned the triannual report to Welsh Government (WG) and that as an evolving process the narrative would improve. She set out there was a statutory duty to undertake calculation of staffing when the purpose of a ward was changed, and to present the calculations to the designated person in order to ensure the best levels of care could be provided.</p> <p>QS21/169.3 An Independent Member raised the matter of Healthcare Support Workers (HCSWs) and whether the quality framework will support consistency on paediatric wards in particular. She would also wish to see the same term utilised across the organisation. The Director of Nursing responded that she recognised that the use of HCSWs and how vacancy risks were mitigated had moved on for adult wards, but a very traditional model of working remained within paediatrics.</p> <p>The Independent Member also noted a comment in the report to data collection on paediatric wards not reflecting true levels of activity and queried if this was due to there often being very short-term admissions onto these wards. A comment was also made that the format and structure of the report made it difficult to identify harms that might</p>	

<p>have occurred as a result of staffing issues, and the Executive Director of Nursing and Midwifery undertook to look at identifying these in a separate appendix for future reports. An Independent Member enquired whether paediatric nurse specialists supported Emergency Departments (EDs) in terms of reducing inappropriate or unnecessary admissions. The Chief Executive indicated that following a recent visit to a paediatric ward in the East this was very much on their agenda in terms of support to ED.</p> <p>QS21/169.4 It was resolved that:</p> <p>The Committee receive the report to gain assurance in relation to the following:</p> <ol style="list-style-type: none"> 1. Betsi Cadwaladr University Health Board (BCUHB) is meeting its statutory 'duty to calculate' the nurse staffing level in all wards that fall under the inclusion criteria of Section 25B of the Nurse Staffing Levels (Wales) Act 2016. 2. BCUHB is meeting its statutory duty to provide an annual presentation to the Board detailing calculated nurse staffing levels 3. The Committee noted that: <ul style="list-style-type: none"> • As of 1 October 2021 the extension of section 25B of the Nurse Staffing Levels (Wales) Act 2016 has been extended to include paediatric inpatient wards. The Annual Presentation and Summary of Nurse Staffing Levels for wards where Section 25B applies will therefore include Adult acute medical inpatient wards; Adult acute surgical inpatient wards; and Paediatric inpatient wards. 4. Ongoing reasonable steps taken to monitor and as far as possible maintain nurse staffing levels in line with the Act and during times of unprecedented pandemic pressures. • Potential financial implications arising from the organisations statutory duty to calculate and take all reasonable steps to maintain nurse staffing levels will be considered by the Executive Team as part of the financial planning process for 2022/23. <p><i>[Alison Griffiths left the meeting]</i></p>	GH
<p>QS21/170 NU06 Prevention and Management of Adult In Patient Falls Policy</p> <p>QS21/170.1 The Executive Director of Nursing and Midwifery reported that she had received some comments directly from an Independent Member in terms of language and format, and she would be looking to introduce easy read principles for future policy submissions. She also acknowledged that the policy should reflect the recent Health and Safety Executive improvement notice regarding falls. An Independent Member added that she would also wish to see consistent terminology throughout the policy when</p>	

<p>referring to staff and/or the workforce, and suggested that other departments should be given the opportunity to comment on the policy – for example radiology. She also asked that the policy be reviewed sooner than the proposed three years.</p> <p>QS21/170.2 The Chair made reference to the statement on page 9 regarding patients with mental capacity and enquired therefore what was the situation for patients without mental capacity. The Executive Director of Nursing and Midwifery indicated this narrative could be refreshed but there was a read-across and links to training for Deprivation of Liberty Safeguards.</p> <p>QS21/170.3 The Chair stated that this was a key policy for the Health Board given there were several falls-related incidents. She suggested that the policy be refreshed to take on board the comments made with the involvement of the Independent Member (Trade Unions), and that she would then take Chair's Action to provide Committee level approval.</p> <p>QS21/170.4 It was resolved that the Committee agree that Chair's Action should be taken to approve the amended policy when it had been revised.</p>	GH
<p>QS21/171 Board Assurance Framework</p> <p>QS21/171.1 The Interim Director of Governance presented the paper, highlighting that it should have been noted as requiring both discussion and decision. He drew members' attention to the recommendations which accompanied the paper.</p> <p>QS21/171.2 An Independent Member referred to BAF21-09 (Infection Prevention and Control - IPC) and asked whether there were sufficient resources being identified. The Executive Director of Nursing and Midwifery stated that the risk needed to be considered in the context of the pandemic and Covid outbreaks, and that the ongoing pressures meant it was unlikely the organisation would be able to deliver the target risk score by the end of the year. It was reported that a new IPC lead had just taken up post and one of her early priorities would be to review the structural requirement around IPC given the lessons learned from the pandemic. It was also noted that progress with BAF21-09 was very much dependent on estates-related matters being taken forward through the Estates Strategy.</p> <p>QS21/171.2 An Independent Member referred to BAF21-12 (security services) and to the challenges around ensuring a structured approach to the use of CCTV. The Acting Associate Director of Quality Assurance confirmed that an incident in a mental health unit was in a communal room not covered by CCTV and whilst there was a recommendation to improve coverage of communal areas, this would not be monitored 24/7 and there were associated privacy requirements to be met. [<i>Gareth Evans left the meeting</i>] An Independent Member referred to BAF21-01 (unscheduled care) and asked whether appropriate representation would be at the workshops to ensure improvements to front door series eg; diagnostics. The Executive Director of Nursing and Midwifery</p>	

<p>undertook to follow this up. The Chair noted that BAF21-01 indicated there were gaps in actions around the delivery of urgent primary care centres, and asked if the organisation was being clear on the efficiency and effectiveness of pathways to achieve this. The Chief Executive confirmed this was the case and was the subject of wider access conversations with Ambulance Service colleagues and others.</p> <p>QS21/171.3 It was resolved that the Committee:</p> <ol style="list-style-type: none"> 1. Approve the transfer of the monitoring of BAF21-07 – Mental Health Leadership Model; and BAF21-11: Culture-Staff Engagement from the QSE Committee to the Partnerships, People and Population Health (PPPH) Committee; 2. Approve the increase in the current risk score for BAF21-19: Impact of Covid-19 to 16 (4x4), from 12 (4x3) in light of ongoing high levels of community transmission; 3. Approve the increase in the current risk score for BAF21-01 Safe and Effective Management of Unscheduled Care to 20 (5x4) from 16 (4x4) in light of ongoing pressures; and 4. Note that further work to review and update the Key Field Guidance is continuing, including consultation with the Good Governance Institute for their advice and opinion. 	GH
<p>QS21/172 Corporate Risk Register <i>[Gareth Evans re-joined the meeting]</i></p> <p>QS21.172.1 The Interim Director of Governance presented the paper, drawing members' attention to the detailed requests for the Committee's attention as set out in paper.</p> <p>QS21/172.2 An Independent Member raised a question regarding how well embedded risk management was across the organisation and whether managers were aware of the risks in their service areas. The Interim Director of Governance was confident that risks were actively being managed through the Datix system and that risk was a core topic for discussion at performance meetings. The Executive Director of Nursing and Midwifery added that talking to staff whilst on walkabouts also was a good indicator as to how familiar staff were with organisational and local risks. The Chair shared her concern that divisional risk registers had a way to go in terms of improvement to allow for robust reporting into Committees, although it was acknowledged that progress had been made over the past year. The Executive Director of Public Health suggested that risk reporting at Committee level was evolving and would be a test of maturity.</p> <p>QS21/172.3 It was resolved that the Committee:</p>	

1. Note the Key Field Guidance Document is currently under revision and will be re-presented to all Committees following the agreement of the updated version.
2. Review and note the progress on the Corporate Tier 1 Operational Risk Register Report as set out within the paper.

QS21/173 Quality and Performance Report

[Kamala Williams and Gavin Halligan-Davis joined the meeting]

QS21/173.1 The Acting Director of Performance presented the report. She highlighted that Child, Adolescent and Mental Health Services (CAMHS) performance was still some way off seeing improvement with figures showing 23.6% against a target for assessment of 80% which was a deteriorating picture since the last report to the Committee. It was noted that only one Health Board was currently achieving this target with most others on a downward trajectory. Performance for therapeutic intervention was currently 16.4% against an 80% target and was also a deterioration since the last report.

QS21/173.2 The Acting Director of Performance then went onto discuss neurological assessments for which an improvement plan was in place with agreed trajectories. An assumption had been made that the target would not be delivered this year, however, the planned process of outsourcing for additional capacity should enable the organisation to deliver this target by the end of March 2023. A validation process was also ongoing which should potentially reduce waiting lists however the delivery of core activity was very dependent upon recruitment success. The Chief Executive added that she had met with neurological colleagues in the West and Centre recently and had found the conversations helpful in understanding the insight the teams had. She was of the view that consideration needed to be given to how the assessments were delivered and to ensure intervention was accessible at key points. The Acting Director of Performance added that virtual assessments had now been commissioned together with alternative options for those patients who had been waiting a very long time. In response to a question from an Independent Member, the Executive Director of Primary Care and Community Services confirmed that face to face consultations for CAMHS and neurodevelopment continued to increase but were not at 100% due to the choice and preference of some patients. He undertook to share latest figures outside of the meeting.

QS21/173.3 An Independent Member expressed her concern at the Sepsis Six performance and was disappointed to note reference to poor data collection and coding. The Executive Medical Director shared this concern and suggested that if coding was not as it should be, this could affect sepsis mortality figures. Also he felt that in basic terms the sepsis recording was almost a proxy marker for wider clinical note-keeping. The Senior Associate Medical Director/Improvement Cymru Clinical Lead confirmed that the number of sepsis admissions was fairly static however there were system related issues due to a change from a paper system to paperless. She informed members of a pilot taking place in Ysbyty Glan Clwyd trialling an alternative data collection proforma and this learning was being shared across networks. The Chair requested that officers

CS

<p>take away an action to provide assurance to the committee that sepsis performance was purely a data capture issue, and not a care intervention issue.</p>	NL
<p>QS21/173.4 The Chair stated that she felt the never events information was now much more helpfully shown in the report and allowed for easier identification of trends although she felt it could be further improved by identifying on which site they had occurred. She then raised the issue of complaint themes and in particular those received regarding accessibility at YGC when families were trying to contact a ward by telephone. The Executive Director of Nursing and Midwifery reported that a range of actions were being considered to provide additional support to these teams including reviewing administrative vacancies and enhancing the hours and roles of ward clerks and house-keepers to address answering of phones without impacting on nursing time. The Executive Director of Workforce and OD reported that work originally established in 2019 regarding additional admin support had been impacted upon by the pandemic and recruitment challenges. The work was to be refreshed with a gap analysis expected imminently ahead of costing.</p> <p>QS21/173.5 It was resolved that members of the Quality, Safety and Experience Committee scrutinise the report and advise any areas to be escalated for consideration by the Board.</p>	MJ
<p>QS21/174 Quality Highlight Report</p>	MJ
<p>QS21/174.1 The Chair indicated that a revised version had been circulated at her request. The Acting Associate Director of Quality Assurance presented the report and drew members' attention to key areas. It was reported that during August and September there had been 19 nationally reportable incidents including 2 never events, and the paper contained a summary of each with the associated learning. He also drew members' attention to a concern around the timely completion of actions. It was also reported that the number of falls was above average and BCUHB had a higher rate per occupied bed days than expected. In terms of Healthcare Inspectorate Wales activity it was highlighted that an inspection had been made to the Hergest Unit in Bangor and a draft report had been received. Following the process of agreeing factual accuracy an action plan would be prepared for approval by the Executive Director of Nursing and Midwifery.</p> <p>QS21/174.2 The Chair remained concerned at how learning was embedded in a sustainable manner, which still was not evident. She indicated that she had suggested to the Health Board Chair and Board Secretary that the Health Board should be sighted on nationally reportable and serious incidents, with the QSE Committee receiving thematic learning reports, as part of a regular performance-suite. The Committee were supportive of this proposal which would be taken forward by the Acting Associate Director of Quality Assurance in liaison with the Executive Medical Director and the corporate Occupational Health and Safety team.</p> <p>QS21/174.3 An Independent Member referred to the incident within the North Wales Cancer Treatment Centre regarding a delay in terms of acting upon abnormal results and</p>	MJ

<p>noted that the paper indicated that a checking system would be put in place. She was concerned if this was not already routinely the case across the Health Board. The Acting Associate Director of Quality Assurance responded that in this particular case the clinician was on leave but he reassured members that immediate action had been taken but there may well be more learning once the investigation was complete. The Executive Medical Director suggested the implementation of a Standard Operating Procedure for abnormal test results was being worked through, but he did feel there was a wider mitigation issue around the organisation's ability to communicate results to the requesting clinicians, and he confirmed that an options appraisal would be going to the Executive Team shortly. The Executive Medical Director also felt it would be remiss not to acknowledge that as an organisation BCUHB often struggled with the timely completion of actions.</p> <p>QS21/174.4 It was resolved that the Committee note the report.</p>	
<p>QS21/175 Covid19 Update</p> <p>QS21/175.1 The Executive Director of Nursing and Midwifery presented the paper and highlighted that the Board had recently recruited a lead to work with herself, the Board Secretary and others to realign the Executive Incident Management Team's terms of reference, improve reporting and strengthen links to cabinet.</p> <p>QS21/175.2 It was resolved that the Committee note the position outlined in the report.</p>	
<p>QS21/176 Quality Awards, Achievements and Recognition</p> <p>QS21/176.1 It was resolved that the Committee note the report.</p>	
<p>QS21/177 Vascular Steering Group Update <i>[Sally Morris joined the meeting]</i></p> <p>QS21/177.1 The Executive Medical Director presented the update report which also sought Committee approval to refreshed terms of reference for the Vascular Network Task and Finish Steering Group. He drew members' attention to the draft revised action plan which he hoped demonstrated a significant step forward in terms of clarity and progress. It was noted that the Vascular Oversight Group was meeting fortnightly and providing a strengthened level of grip to this matter and heightened quality clinical ownership.</p> <p>QS21/177.2 An Independent Member suggested that the finish date of the end of November for the steering group may be optimistic although it was noted the timeframe could be further reviewed. She felt that the subsequent paper to the November Health Board should be very clear where any actions were directly aligned to the timeframe of the Royal College report, and that the start and end dates needed to be achievable. It</p>	

<p>was also noted that the paper made reference to a letter having been received by the Health Board and that Independent Members had been briefed on this ahead of the vascular item due at Health Board on the 18 November 2021. The Executive Medical Director stated that as part of the Board paper there would be more clarity on how the review of decision making around centralising vascular services would be taken forward, clarity on current structures and clarity on where the safety concerns were. He reminded members that the Royal College of Surgeons (RCS) external review had specifically focused on safety but the findings with regard to the second part of the review were not yet known and that, due to capacity issues within the RCS, may not be available until January. The Chair acknowledged that with yet another iteration of an action plan for vascular services and continued concerns at the lack of progress, it was understandable that some members of the public would lose confidence. She stated that the organisation must now ensure it could evidence improvement and be clear on the reasons for slippage against actions.</p> <p>QS21/177.3 It was resolved that the Committee note the update from the Vascular Steering Group and approve the Terms of Reference</p>	
<p>QS21/179 Immunisation Programme Delivery in BCUHB to September 2021 – <i>[Taken out of order at Chair's discretion]</i></p> <p>QS21/179.1 The Executive Director of Public Health presented the paper and acknowledged the work that goes into the wider immunisation programme which had continued throughout the pandemic. The paper provided an update on activity across a range of services including primary care, occupational health, school nursing and others. She noted that whilst not at 100% which would be desirable, uptake numbers were running extremely high given the Covid context and this was commendable.</p> <p>QS21/179.2 An Independent Member enquired as to the position with regards to immunisations in HMP Berwyn and the Executive Director of Public Health indicated that this data was regularly received and she would provide this outside of the meeting. The Independent Member also asked whether there was any evidence that anti vaccination demonstrations across North Wales had impacted on take up by young people and children. The Executive Director of Public Health was not aware of specific evidence to support this concern, but she was keen to ensure that partnership communications continued to share the evidence that immunisations programmes remained one of the best ways in which to protect population health. An Independent Member noted that the paper referred to workplace vaccines and that data was not collected other than for flu, however, she suggested that as other vaccines were mandated by the Health Board as an employer then there should be other data sets available. She suggested it would be interesting at some point to compare the data for uptake against mandated vaccinations. The Executive Director of Public Health indicated that the occupational health vaccination status of staff has been a concern previously and would be an area of focus when the Strategic Immunisation Plan was refreshed. The Executive Director of Workforce and OD added that there were compliance records for staff but there was now</p>	TO

<p>a backlog which had worsened during the pandemic. A case for improvement had been supported by the Executive Team and a clear recovery plan was now identified. The Chair wished to commend primary care colleagues for their hard work in ensuring a high uptake on immunisations despite the challenges over the past 18 months.</p> <p>QS21/179.3 It was resolved that the Quality, Safety and Experience Committee scrutinise the report.</p>	
<p>QS21/181 Quality Assurance Review – Morfa Ward, Llandudno General Hospital <i>[Taken out of order at Chair's discretion. Reena Cartmell, Amy Kerti, Tracey Williamson, John Stewart and Anne Stewart joined the meeting]</i></p> <p>QS21/181.1 The Executive Director of Nursing and Midwifery asked those attending to introduce themselves, and in particular welcomed Mr and Mrs Stewart who had supported the review as service users. The Associate Director of Nursing presented the paper. She wished to record her thanks to Mr and Mrs Stewart for their involvement and to the dementia nurses for their role in taking the review forward. It was also acknowledged that the CHC had been heavily involved together with the relevant safeguarding boards and that objectivity and transparency were key aims for the review. It was also clarified that a separate HR investigation was ongoing.</p> <p>QS21/181.2 The Associate Director of Nursing reported that a triangulated approach would be required to maximise the significant learning coming out of the report. Following a valuable desktop review of the evidence, methodology had been applied across all community hospitals. Members' attention was drawn to the recommendations of the review and that person centred and dignified care were key areas for learning and which had resulted in immediate actions for the ward and the wider Llandudno site. These included stabilising compassionate nursing leadership, standardising of a dementia friendly environment, take up of safeguarding ambassadors and a review of skill mix and acuity.</p> <p>QS21/181.3 The Nurse Consultant for Dementia added that staff had been readily available to the reviewing team and had been candid in their responses. In addition, patients and service users had spoken openly with the reviewers and there were many examples of good practice to commend too. Mr John Stewart outlined his experience and noted that on the whole patients were more willing to share their views than the staff. He acknowledged that the Morfa Ward did have environmental issues in terms of caring for patients living with dementia, however, he felt that the overall standards of care were good and he would personally be happy if he was admitted to the Ward.</p> <p>QS21/181.4 The Associate Director of Nursing acknowledged there was work to take forward in relation to identified medication omissions. She stated that the reporting from the Datix system had appeared quite high for the ward and that pharmacy colleagues had been asked to undertake an independent review which had identified patterns of medication being refused or not taken by patients. This has resulted in a BCUHB-wide recommendation regarding supporting patients in taking their critical medication.</p> <p>QS21/181.5 An Independent Member raised the matter of culture and the visibility or otherwise of senior management. The Associate Director of Nursing responded that</p>	

there was certainly a correlation between culture and leadership and that the report into the Morfa ward made it clear that improvements to compassionate leadership needed to be made with leaders being able to hear concerns first hand. The Nurse Consultant for Dementia noted that many staff had indicated that they know how to raise a concern but did not feel able to do so, and that the student nurses who did so should be commended. Students had also noted that the presence of University supervisors wasn't what it could be, and that the period early in the pandemic had of course reduced the number of staff on sites which had left some staff feeling isolated. The Independent Member asked if there had been unnecessary delays in escalation and it was accepted that a lack of awareness of the process coupled with the ward manager not being available or approachable could have contributed to some delays. The Independent Member then enquired about the robustness of the dashboard data. The Associate Director of Nursing accepted that there were issues in terms of bringing any concerns or red risks under control in a timely fashion. The Executive Director of Nursing and Midwifery indicated there were plans in hand with informatics colleagues to make the dashboard more intelligent to help with cross-referencing and triangulation.

QS21/181.6 The Executive Director of Workforce and OD indicated that there were a number of key learning areas from the report which should be incorporated alongside other workforce aspects coming out of the discovery phase of Stronger Together and the Speak out Safely campaign. She noted that there were sometimes unintended consequences of decisions, for example the redeployment of staff to other roles. She felt that excellent care would come from multi-professional teams and there was a need to encourage people to speak out across all professions.

QS21/181.7 An Independent Member noted the reference to undignified utensils and crockery being utilised on the ward and felt this was a very basic point that could be addressed to provide real improvement for patients and families. Finally she suggested that the Speak Out Safely and Work in Confidence campaigns should be extended to the student workforce too, and the Executive Director of Nursing and Midwifery confirmed the campaigns had been appropriately shared with the University.

QS21/181.8 The Associate Director of Nursing confirmed she and other leaders were passionate to eradicate the inappropriate language that was often applied to patients living with dementia, for example the use of the word 'aggressive' which she felt should be eradicated. The Executive Director of Nursing and Midwifery added that work around a multi-professional approach and shared governance would also support improvements and that community teams can sometimes feel quite isolated. A network approach would be key to addressing this and to ensure they can access support on a day to day basis. The Nurse Consultant for Dementia added that techniques for cascading information need to be strengthened as currently there is an over reliance on email cascade. In response to a question from an Independent Member it was confirmed that community hospitals were operationally responsible to the Executive Director of Primary Care and Community Services, but individually and professionally to the Executive Director of Nursing and Midwifery and the Executive Medical Director. It was noted that the Primary and Community Services senior management team were to discuss the Morfa report next week. The Independent Member would wish to have seen more clarity around accountability for developing a response to and improvements as a result of the report. The Executive Director of Nursing and Midwifery confirmed that this would be a BCU-wide approach wider than community hospitals.

<p>QS21/181.9 The Chair thanked everyone for their contributions and stated that the main outcome of the report should be for the organisation to demonstrate excellent person-centred care and to ensure that vulnerable patients including those with dementia were appropriately cared for in any setting. She expressed concern over the number of systemic flags identified in the report that should have raised questions about how the ward was operating but did not. She reiterated the need to implement robust actions following the review and demonstrate embedded learning as a result.</p> <p>QS21/181.10 It was resolved that the Quality, Safety and Experience Committee receive the report for assurance</p> <p><i>[Reena Cartmell, Amy Kerti, Tracey Williamson, John Stewart and Anne Stewart left the meeting]</i></p>	
<p>QS21/178 Operational Report : Children's Services <i>[Liz Fletcher joined the meeting]</i></p> <p>QS21/178.1 The Assistant Area Director for Children's services had prepared a presentation and members were invited to raise questions or comments. An Independent Member noted with concern that there were staffing issues within the Sub Regional Neonatal Intensive Care unit, which was meant to be a flagship service. The Executive Director of Primary Care and Community Services accepted this was a valid concern but that the absences were predominantly covid or maternity related rather than actual vacancies. The Independent Member went onto ask how pressures were managed and escalated. The Assistant Area Director for Children's services assured the Committee that in times of real challenge then professional judgement would be executed as to whether a matter would require escalation to ensure the service wasn't compromised across any of the three units. On a day to day basis the service managers on each site would monitor the situation and escalate as appropriate.</p> <p>A question was asked whether there were any issues in terms of patient transfers to Alder Hey. The Assistant Area Director for Children's services indicated there was an internal transport service for neonates between the three BCUHB units, and she was not aware of any poor outcomes in terms of external transfers despite tertiary care in England and Wales being quite pressured.</p> <p>QS21/178.2 In terms of respiratory winter plans it was reported that the predicted surge had not materialised although the service remained busy. With regards to CAMHS and targeted improvement there were early positive indications. The Assistant Director of Children's services reported she would be taking on the thematic lead for neurodevelopment and hoped to clarify a complex position on a whole service basis. A project group and nominated support would be set up.</p>	
<p>QS21/180 Quality Governance Self Assessment Action Plan</p> <p>QS21/180.1 The Acting Associate Director of Quality Assurance presented the paper, highlighting there remained three open actions pertaining to the Quality Strategy, the Clinical Strategy and clinical pathway work as part of the transformation agenda. He</p>	

<p>noted that Audit Wales had undertaken a review of quality governance and the draft report was anticipated in the next couple of weeks. This report would then provide a further set of recommendations and it was proposed that the outstanding actions from the current action plan be incorporated into a single improvement plan. The Chair enquired whether the original self-assessment should be reviewed and the Acting Associate Director of Quality Assurance indicated that it would be cross-referenced against the Audit Wales report when received.</p> <p>QS21/180.2 It was resolved that the Committee note the report and update of the Quality Governance Self-Assessment Action Plan.</p>	MJ
<p>QS21/184 Royal College of Physicians President's Visit to Wrexham Maelor Hospital</p> <p>QS21/184.1 The Executive Medical Director provided a verbal update on the visit which would report formally to the PPPH Committee as it was focused on workforce morale and behaviours. He indicated that the content of the report was challenging and that a range of actions had been instigated with the senior leadership teams, with whom there was a good level of engagement. The Chair stated that the PPPH Committee would refer on any significant patient safety issues that were identified.</p>	
<p>QS21/182 Welsh Ambulance Services NHS Trust - Review of Patient Safety, Privacy, Dignity and Experience whilst Waiting in Ambulances during Delayed Handover</p> <p>QS21/182.1 The Chair invited any comments and questions on the report. An Independent Member pointed out that many of the actions within the action plan were already nearing their due date. She also felt that the actions were too task orientated and there should be a more whole system approach. The Executive Director of Nursing and Midwifery responded that the organisation had had to turn the action plan around quickly for Healthcare Inspectorate Wales but she assured members there was an ongoing improvement approach alongside unscheduled care work. An Independent Member was concerned to read that 41% of WAST staff were not aware who had responsibility and accountability for the patient at all times. She also highlighted the importance of close communication between ED staff and WAST, acknowledging how busy teams were.</p> <p>QS21/182.2 The Chair recalled a Regulation 28 some years previously relating to ambulance handovers and was disappointed that the corrective actions put in place at that time do not appear to have been sustained. The Executive Director of Nursing and Midwifery indicated that whole system pressures and staffing challenges would have contributed to this. The Chair suggested that there were still a large proportion of unnecessary ambulance conveyances to hospital, however, the Executive Medical Director provided a recent example where over 100 patients in an ED had been triaged and all had been deemed appropriate. The Executive Director of Nursing and Midwifery</p>	

<p>added that the action plan would be dovetailed into the wider unscheduled care implementation plan reporting to the PFIG Committee.</p> <p>QS21/182.3 It was resolved that the Committee note the HIW report and the Health Board's action plan response.</p>	
<p>QS21/183 Public Service Ombudsman for Wales - Public Interest Report (Urology Services)</p> <p>QS21/183.1 The Chair confirmed that the Committee had received the report in private session in September and following formal publication by the Ombudsman it could now be received in public session, together with the draft terms of reference for the invited review. It was confirmed that the improvement group would meet for the first time later in November. [<i>Jackie Allen left the meeting</i>]. An Independent Member noted reference to divisional clinical directors and enquired whether that related to urology as a division or surgical or another. It was clarified that as the leadership for urology was currently under review, scrutiny would be through the overarching improvement group.</p> <p>QS21/183.2 It was resolved that the Committee to note the Public Service Ombudsman for Wales' Public Interest Report for information which was published on 09 September 2021.</p>	
<p>QS21/185 Radiation Protection Annual Report 2020-21</p> <p>QS21/185.1 It was resolved that the QSE Committee approve the Annual Report of the Radiation Protection Committee (2020/21)</p>	
<p>QS21/186 Annual Organ Donation Report</p> <p>QS21/186.1 It was resolved that the Committee note for information the report contents and future aims and objectives of the Organ Donation Committee.</p>	
<p>QS21/187 Public Services Ombudsman for Wales Annual Letter 2020/21</p> <p>QS21/187.1 It was resolved that the Committee receive and note the report and PSOW Annual Letter</p>	
<p>QS21/188 Annual Clinical Audit Report 2020-21</p> <p>QS21/188.1 It was resolved that the Committee approve the annual report.</p>	
<p>QS21/189 Patient Safety Quality Group (September)</p>	

QS21/189.1 It was resolved that the Committee receive the Chair's report	
QS21/190 Patient Safety Quality Group (October) QS21/190.1 It was resolved that the Committee receive the Chair's report	

<p>QS21/191 Clinical Effectiveness Group</p> <p>QS21/191.1 It was resolved that the Committee receive the Chair's report</p>	
<p>QS21/192 Strategic Occupational Health and Safety Group</p> <p>QS21/192.1 It was resolved that the Committee receive the Chair's report</p>	
<p>QS21/193 Patient and Carer Experience Group</p> <p>QS21/193.1 It was resolved that the Committee receive the Chair's report</p>	
<p>QS21/194 Issues Discussed in Previous Private Session</p> <p>QS21/194.1 It was resolved that the Committee note the report</p>	
<p>QS21/195 Documents Circulated to Members</p> <p>6.9.21 Follow on action regarding neurodevelopment assessments 6.9.21 Follow on action regarding HMP Berwyn Covid outbreak 22.9.21 Briefing note on CAMHS</p>	
<p>QS21/196 Agree Items for Chair's Assurance Report to Board</p> <p>QS21/196.1 Agreed to include the management of deteriorating patient and sepsis discussion, and the referral of Nurse Staffing reporting to PPPH Committee.</p>	
<p>QS21/197 Review of risks highlighted in the meeting for referral to Risk Management Group</p> <p>QS21/197.1 The Chief Executive suggested that risks around sepsis might need further consideration</p>	
<p>QS21/198 Review of Meeting Effectiveness</p> <p>QS21/198.1 Members felt that the meeting had been too long to maintain concentration. The Chair indicated the length and focus of Committee meetings had been raised at the recent Board Development session and the Chief Executive indicated this would be addressed.</p>	
<p>QS21/199 Date of Next Meeting</p> <p>11.1.22</p>	

QS21/200 Exclusion of Press and Public

QS21/200.1 It was resolved that representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
Officer/s	Minute Reference and summary of action agreed	Original Timescale	Latest Update Position	Revised Timescale
4th May 2021				
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	<p>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.</p> <p>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).</p> <p>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.</p>	<p>September</p> <p>February</p>
6th July 2021				
K Williams	QS21/97.4 QPR	August	31.8.21 the separate COVID reports routinely include information on GP consultations.	Closed

	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		<p>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.</p> <p>2.11.21 S Hill to follow up and ensure this action can be closed off.</p> <p>05.01.22 The Performance team will include actual GP consultation activity in the next report.</p>	<p>January</p> <p>March</p>
S Evans-Evans	<p>QS21/99.5 CRR</p> <p>Arrange for ET discussion around consistency of RAG rating terminology as it was noted that green in the CRR meant completed whereas in the annual plan it meant on track but not necessarily complete.</p>	August	<p>7.9.21 S Evans-Evans to progress</p> <p>2.11.21 G Harris confirmed is progressing with risk owners and support teams. Chair asked that the action be left open until further assurance given around ability to close it down.</p> <p>05.01.22 A meeting is being scheduled before the end of January with SEE, GH, SH & CS to agree a consistent RAG rating for all documents.</p>	<p>November</p> <p>January</p> <p>February</p>
M Smith A Thomas	<p>QS21/105.4 Mental Health</p> <p>Provide a thematic analysis on psychological services to the November meeting.</p>	November	<p>21.7.21 Division seeking confirmation that this should be joint adult and CAMHS format.</p> <p>7.9.21 C Stockport clarified this would be a joint report.</p> <p>22.10.21 Paper deferred to January meeting</p>	November

			<p>2.11.21 L Reid wished to clarify that the paper would address psychological services across the Health Board as a whole, not just within MHLDS. A Thomas confirmed the paper would be ready for the January meeting.</p> <p>Due to staff sickness, it has been necessary to defer the report again</p>	<p>January</p> <p>March</p>
7th September 2021				
<p>L Reid G Harris</p>	<p>QS21/127.1 Outputs from Workshop Work to develop proposal for taking forward outputs and key points from workshop</p>	<p>November</p>	<p>Chair will update verbally at November meeting. 2.11.21 L Reid indicated that key points from the workshop had been identified:</p> <ul style="list-style-type: none"> 1) The importance of accurate and timely data to inform Committee deliberations. She had met with S Hill in this regard and the associated conversations around the format of the QaPR would also support this action. 2) Lines of assurance to be strengthened to support reporting. 3) 3) The focus of future QSE Committee agendas. <p>05.01.22 Date being scheduled in January with LR, GH & PPJ. Other attendees will be brought in as necessary with the output being that future agendas reflect the output of the workshop.</p>	<p>Closed</p>

S Green	QS21/130.2 BAF Consider whether the psychological impact of staff returning to work post-isolation should be built into a relevant risk either on the BAF or Corporate Risk Register	November	<p>14.10.21 Staff who are returning to work who have been shielding have a site specific risk assessment (RA) undertaken on their return with adjustments made to ensure a Covid safe environment is in place with enhanced PPE if required. A consultant medical practitioner, the manager, HR Team and OH&S, supports the RA process. The staff wellbeing support service provides a range of emotional/psychological support services brought together to meet a range of needs for staff encompassing counselling (through the Occupational Health and Wellbeing service and RCS), clinical psychology, coaching and the support of a network of Wellbeing Champions. A pathway to support staff in crisis is also being finalised with the MHL Division. A Strategic Lead for the Staff Wellbeing Service has been recruited – who is a Consultant Clinical Psychologist – who will manage and continue to further develop the staff wellbeing service across the Health Board, working with and leading a multi-disciplinary Wellbeing Cell to take forward this work, the latter reporting to the newly re-established Health and Wellbeing Group, which met in September 2021. Reports and risks identified are escalated via the WOD Risk Management Group and report to the Strategic Occupational Health and Safety Group. If significant risks are identified, they will be escalated through the governance structure.</p> <p>2.11.21 J Hughes suggested that the update above did not answer the question. S Green commented</p>	Closed
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			that she would reopen the action to ensure this was more explicitly built into the Covid risk. 05.01.21 This is being updated on the risk register.	End of January
L Brereton S Evans-Evans	QS21/130.3 BAF Take BAF21-04 (planned care) back to RMG for deep dive comparison alongside different approach taken with security risk	November	25.10.21 Deep dive on planned care BAF risk planned for December RMG. Deep dive on Security and H&S BAF risks undertaken at the October RMG. The last RMG was stood down due to Gold Command pressures.	December March
G Harris N Lyons M Joyes	QS21/137.2 Pharmacy & Medicines Management Work to determine if learning from medication incidents could be more meaningfully incorporated into other reporting mechanism	November	19.10.21 A meeting has taken place with key executive, clinical and quality leaders and a paper is being submitted to QSE outlining the issues with a full action and improvement plan at the QSE meeting in January 2022. 05.01.21 On QSE January Agenda	January Closed
N Lyons	QS21/137.3 Pharmacy & Medicines Management Follow up the issue of pharmacy support to mental health teams	November	25.10.21 Recruitment has been progressed and an update will be provided in Jan 2022 05.01.22 In progress, final dates for interview still to be confirmed.	January March
G Harris [R Gerrard]	QS21/139.5 YG Outbreak review Consider learning from human factors perspective in developing guidance for staff	November	2.11.21 G Harris confirmed that the new IPC lead had just taken up her post and would pick up on this action. The transformation work led by C	January March

	on coping mechanisms and techniques, on a scale wider than just Covid.		Stockport in terms of human factors would also be related.	
2nd November 2021				
N Lyons	QS21/160.2 Patient (Vascular) Story An Independent Member queried whether the tissue removal procedure that had been undertaken in a ward setting had been appropriate in terms of maintaining patient dignity and whether this was a normal occurrence. The Executive Medical Director responded that this had been debated and challenged at the Vascular Steering Group and an action had been taken away to identify best practice. The Chair would wish the Committee to be sighted on the outcome of these discussions.	January	05.01.22 This has been reviewed in detail and discussed at Vascular Steering Group and actions included within the Vascular Improvement Plan and the QSE Committee will be sighted on these as it reports.	Closed
M Joyes	QS21/167.3 Quality Strategy Interim Priorities The Acting Associate Director of Quality Assurance undertook to take on board all the comments made, and circulate refreshed version to members.	December	Dec 2021 - The document was updated.	Closed
G Harris	QS2/169.3 Nurse Staffing A comment was also made that the format and structure of the report made it difficult to identify harms that might have occurred as a result of staffing issues, and the Executive Director of Nursing and Midwifery undertook to look at identifying these in a separate appendix for future reports.	January	05.01.22 Noted, this will be updated on the next report.	May

G Harris	QS21/170.3 Falls Policy Refreshed policy to take on board the comments made with the involvement of the Independent Member (Trade Unions), and progress through Chair's Action to provide Committee level approval.	December	05.01.22 The Policy has been updated in line with Chair's comments, GH's comments and IM comments. Is now being taken forward as Chair's Action	End of January
G Harris	QS21/171.2 BAF Check that appropriate representation had been invited to the workshops referred to in BAF21-01 (unscheduled care) to ensure improvements to front door series eg; diagnostics.	November	05.01.22 Confirmation received that diagnostics are involved improvement programme.	Closed
C Stockport	QS21.173.2 QaPR Share latest figures for face to face consultations for CAMHS and neurodevelopment.	November	5/1/22 Spreadsheet circulated to QSE members. It is noted that the virtual figures include telephone and video link consultations.	Closed
N Lyons	QS21/173.3 QaPR Provide assurance to the committee that sepsis performance issue was purely a data capture issue, and not a care intervention issue.	December	Further review of the Management of Sepsis shows that there is both a quality of data issue and also improvement needed in clinical management. The improvements needed are currently being developed and will be brought to QSE in March.	March
M Joyes	QS21/174.2 Quality Highlight Report In liaison with the Executive Medical Director and the corporate Occupational Health & Safety team, take forward the proposal to sight the Health Board on nationally reportable and serious incidents, with the	January	Dec 2021 – A meeting was held with the Committee Chair, Executive Lead and Board Secretary to progress. Other stakeholders will be involved. A first draft is intended for submission to the Board in January.	Closed

	QSE Committee receiving thematic learning reports, as part of a regular performance-suite.			
T Owen	QS21/179.2 Immunisations Update Provide data outside of the meeting on the position with regards to immunisations in HMP Berwyn.	November	05.01.22 – Circulated on 26.11.21	Closed
M Joyes	QS21.180.1 Quality Governance Assessment Cross reference the original self-assessment against the Audit Wales report when received.	January	Dec 2021 – The Audit Wales Report has not yet been received.	March

05.01.22

Health Board
18.11.21



Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

To improve health and provide excellent care

Committee Chair's Report

Name of Committee:	Quality, Safety and Experience (QSE)
Meeting date:	2 ND November 2021
Name of Chair:	Lucy Reid, Committee Chair and Independent Board Member
Responsible Director:	Gill Harris, Executive Director of Nursing / Deputy CEO
Summary of business discussed:	<p>The Committee received the following:</p> <ul style="list-style-type: none"> • A story following the experience of a patient who had used the vascular services in Ysbyty Glan Clwyd • The Quality Strategy Interim Priorities for the next twelve months • An update on the implementation of the new Liberty Protection Safeguards and the actions taken to prepare • Nurse Staffing Levels report on the statutory duty to calculate staffing on relevant wards • Board Assurance Framework and the Corporate Risk Register • Quality and Performance Report for September 2021 • Quality Highlight Report for the months August and September 2021 • Covid 19 Update including community transmission rates and progress against the vaccination programme • Quality Awards, Achievements and Recognition highlighting staff achievements • Vascular Steering Group Update including the revised action plan and the terms of reference for the Vascular Steering Group • Operational report for Children's Services • Immunisation Programme Delivery Report to September 2021 • An update against the Quality Governance Self-Assessment Action Plan <p>The following annual reports were received and can be viewed through this LINK</p> <ul style="list-style-type: none"> • Radiation Protection 2020/21 • Annual Organ Donation Report • Public Services Ombudsman for Wales Annual Letter • Clinical Audit Report
Key assurances provided at this meeting:	<ul style="list-style-type: none"> • The immunisation programme delivery report provided progress on the delivery of key vaccination and immunisation programmes. Childhood immunisations and influenza

	<p>programmes have continued to deliver with increased uptake across many areas. This is particularly encouraging given the additional pressures on resources as a result of the Covid-19 vaccination.</p>
Key risks including mitigating actions and milestones	<ul style="list-style-type: none"> • The Quality Assurance Review undertaken for the Morfa Ward, Llandudno Hospital highlighted a number of areas of concern regarding governance and practices. The review was undertaken because of concerns raised by student nurses working on the ward. The review has resulted in a number of recommendations being made relating to leadership, governance, safeguarding and reporting. • Healthcare Inspectorate Wales (HIW) have undertaken a review of patient safety, privacy, dignity, and experience of patients who have had a delayed handover between Wales Ambulance Services Trust (WAST) and the hospital. The review recognised the significant pressures across the whole system in Wales and various initiatives in progress at a national level. However, HIW have noted that it is unclear how effective some of the initiatives have been. An action plan has been developed in partnership with WAST. • Concerns were raised in relation to the management of Sepsis in the emergency department. The Quality and Performance Report identified problems with data capture, however the Committee were concerned that it was unclear whether this was a data capture issue or compliance with the Sepsis 6 bundle and have requested further work be undertaken. • The Public Interest Report on Urology Services was received and discussed in private session in September. The Committee supported an independent royal college review of the urology service to provide an in-depth analysis of service performance and patient safety. • The Committee received a report on vascular services and approved a terms of reference for the renewed Steering Group. However, the Committee remain concerned about the development of another action plan under new leadership and still does not have assurance with respect to the service itself. The Committee supports the focus on evidence based progress for future reporting.
Targeted Intervention Improvement Framework Domain addressed	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • QSE recommended that Nurse Staffing reports (including for the Mental Health Learning Disabilities Division) be transferred to the Partnerships People & Population Health (PPPH) Committee's cycle of business as the Committee with responsibility for workforce/people. A caveat was agreed that PPPH would refer on any significant safety issues to QSE and financial issues to

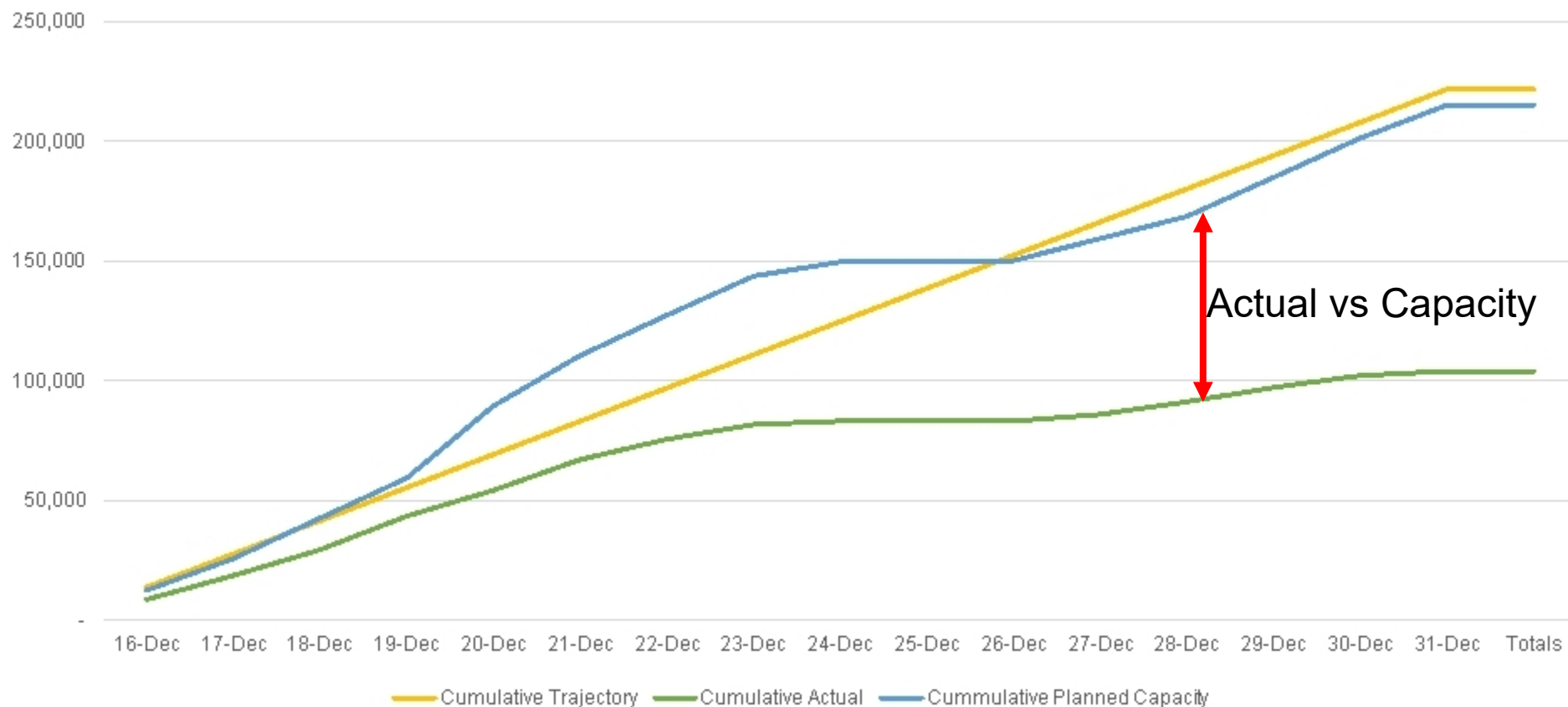
	<p>Performance Finance & Information Governance (PFIG) Committee.</p> <ul style="list-style-type: none"> QSE Committee were informed that the report from Royal College of Physicians President's Visit to Wrexham Maelor will be considered by PPH Committee
Matters requiring escalation to the Board:	The Committee have requested, with the support of the Chair, that quality and safety reporting directly to the Board should be strengthened. The reporting parameters will be agreed to ensure that the Board is appropriately sighted on quality and safety whilst the Committee will focus on the overall themes and learning to provide assurance to the Board.
Well-being of Future Generations Act Sustainable Development Principle	<p>The Committee gave adequate consideration to the sustainable development principles:.</p> <ol style="list-style-type: none"> 1.Balancing short term need with long term planning for the future; 2.Working together with other partners to deliver objectives; 3. Involving those with an interest and seeking their views; 4.Putting resources into preventing problems occurring or getting worse; and 5.Considering impact on all well-being goals together and on other bodies)
Planned business for the next meeting:	<p>Range of regular / standing items plus:</p> <ul style="list-style-type: none"> Thematic analysis on BCU-wide psychological services Learning from medication incidents Internal Audit report into HASCAS Lone Worker report Community Services Deep Dive – learning from Morfa Ward (Llandudno) issue
Date of next meeting:	11.1.22

Covid-19 Vaccination Programme Report Gold Command

10th January 2022

Surge Booster Programme Trajectory

BCU SITE DELIVERY PLAN

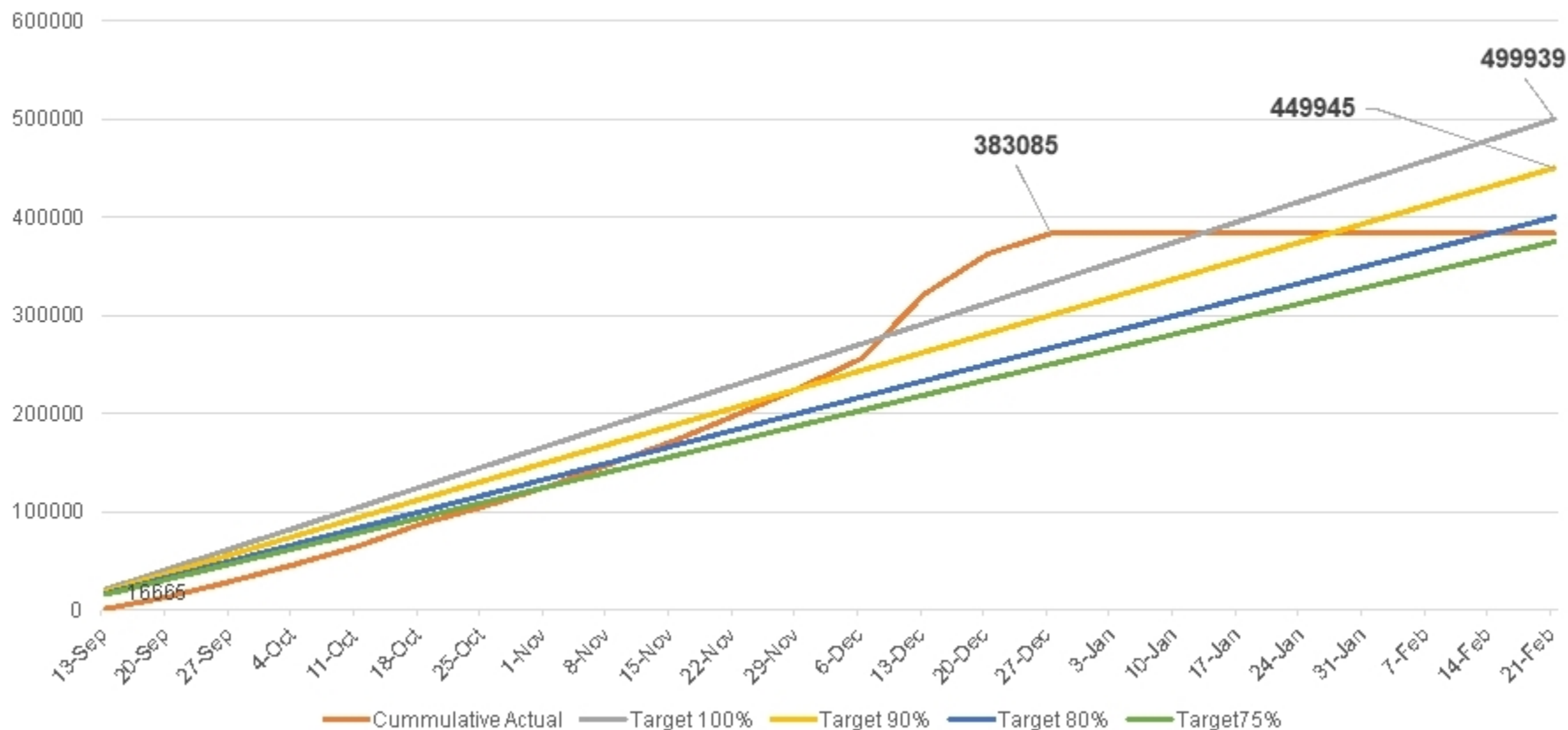


Booster Programme

Actual vs Eligible – 10/01/22

Actual vs Eligible 3rd/Booster Cohort

BASED ON 2ND DOSE COHORT 04/01/22



Comparative Delivery 3rd + Booster

NHS Region code	NHS Region of residence name	Total 1st doses ⁵	Total 2nd doses ⁶	Total booster or 3rd doses ⁷	Cumulative total doses to date ⁸	% Booster / 3rd Dose Delivered
17th December						
	ENGLAND	42,611,175	39,040,796	19,718,497	101,370,468	51%
	WALES	2,515,880	2,319,520	1,239,735	6,075,135	53%
	BCUHB	542,906	498,730	274,570	1,316,206	55%
5th January						
	England	43,545,158	39,857,874	28,823,969	112,227,001	72%
	Wales	2,532,164	2,345,811	1,742,050	6,620,025	74.3%
	BCUHB	563,308	518,941	386,360	1,468,609	74.5%

Programme Update – 10/01/22

- As of 10.01.22 at 09:02 **389,493** booster vaccinations have now been administered
- **10,803** Third Primary Doses have been administered.
- As of 10.01.22 at 09:02, 1st dose vaccinations totalling **564,515** and 2nd dose vaccinations totalling **521,079** have been provided, totalling **1,486,104**. As of 10.01.22 at 09:02, **18,086** 12-15 year olds have been vaccinated.
- As of 10.01.22 at 09:02, **14,882** 16-17 year olds have been vaccinated. Appointments are from 3pm onwards and weekends to accommodate school times.
- As of 10.01.22 at 09:02, **78%** of all eligible citizens have been Booster Vaccinated.
- All Wales position for eligible Third Doses and Boosters currently sits at 73.5% are vaccinated. BCU stands at 74.9%.
- Walk-ins are now available for all those who are eligible across all of our Vaccination Sites.
- BCU will commence with the 5-11 year olds from 22nd January as we will receive a Paediatricians Formulation of the vaccine to administer. To vaccinate with 1st and 2nd dose by the end of April due to the expiry date of the vaccine. This cohort will require an 8 week interval between doses.
- JCVI decision to **NOT** vaccinate Care Homes and those over 80 with a 4th dose at present.
- Those redeployed staff to the programme are being evaluated on who we can release back into the organisation ASAP.
- Areas are linking in with their Local Authorities' to understand their Homeless Cohort numbers and what we can do to reach this cohort further.
- Delivery Capacity increased to meet the target of all eligible citizens to be offered a vaccination by 31st December 2021.
- increased the total number of vaccinations given from 108,181 in November to 188,188 in December.
- The cohort for the Booster programme is 1-9, that includes those age 16-49 entitled to an annual flu vaccination. Of which **ALL** will be eligible for a Booster vaccination by the 31st December, Including those 40-49.
- 01-12 Dec we administered 53,523 and 13-30 Dec we administered 134,665 with 47,793 and 121,084 Boosters respectively over the same time period.
- MACCA support is in place within BCU, 18 personnel on received 21.12.21 to support until February 2022.
- Successful operational set up of Community Pharmacies, potential to administer up to 3000 extra vaccinations per week across North Wales.
- Mobile Dental Units are soon to be online once again to assist in rural areas.

Actions required:

- Staffing resources, which the teams are currently working on allocating support staff to training and sites.
- Following the recent changes to the use of Pfizer, we are working through on what the positive impacts will be on our plans and the ability to engage with the hard to reach cohorts through targeted use of heat maps.
- Review of the Business Case for the Immunisation Centre and workforce implications.
- Continue to push low uptake areas in the communities.

Programme Data – to 10/01/22

(Data extract 08:27 hrs 10/01/22)

Vaccinations Given by Week

Programme Phase ● Phase 1 ● Phase 2



Total Doses Given
1,486,104

Pfizer Biontech
824,374

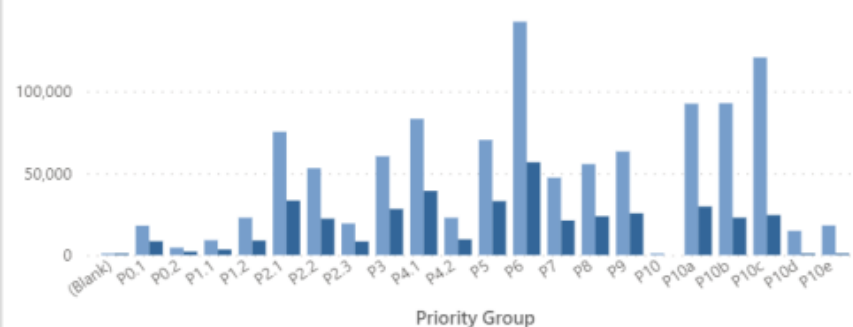
Astrazeneca
559,678

Moderna
101,809

Third/Booster Doses
400,296

Vaccinations Given by Priority Group

Programme Phase ● Phase 1 ● Phase 2



Vaccination Summary by Local Authority

Local Authority	Vaccines Given Yesterday	Vaccines Given This Month	Total Vaccines Given
1. Isle of Anglesey	411	2,346	151,493
2. Gwynedd	1,254	4,787	247,703
3. Conwy	561	2,868	250,999
4. Denbighshire	257	1,763	205,502
5. Flintshire	549	4,258	320,453
6. Wrexham	512	3,700	275,822
Other	29	330	34,132
Total	3,573	20,052	1,486,104

Programme Data

Eligibility by Dose – to 10/01/22

(Data extract 08:27 hrs 10/01/22)

Booster Activity by Appointment Date

● Booked ● Vaccinated

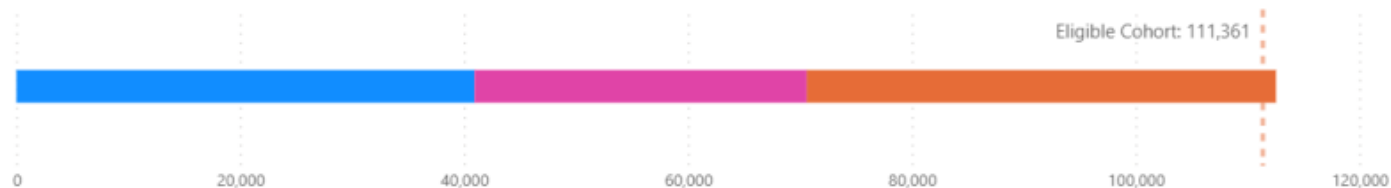


[Data Quality](#)
Click here to follow link

[Summary Dashboard](#)
Click here for activity report

Patients awaiting Booster Dose

● Booked ● Cancelled ● Unbooked



Total Cohort Size

657,013

Total Patients

18,074

Opt Out

3,915

Suspended

Dose 1

564,515

Vaccinated

1,084

Booked

76,308

Unbooked

86%

% Vaccinated

Dose 3

11,351

Total Patients

10,015

Vaccinated

35

Booked

88%

% Vaccinated

Dose 2

521,079

Vaccinated

3,021

Booked

33,179

Unbooked

79%

% Vaccinated

Booster Doses

500,854

Total Patients

389,493

Vaccinated

41,916

Unbooked

78%

% Vaccinated

Booster Programme Data by GP Location to 10/01/22

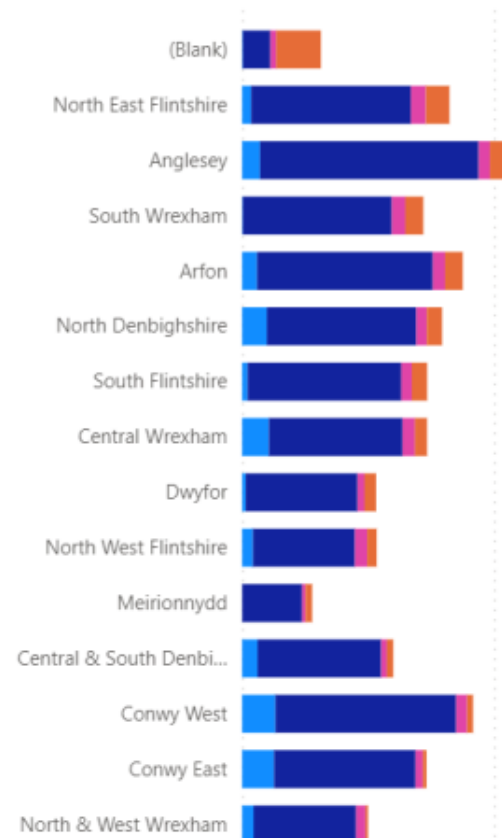
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Total Patients by Booster Status

Area	Vaccinated	% Vaccinated	Booked	Cancelled	% Responded	Unbooked	Eligible
<input type="checkbox"/> Total	5,475	35%	131	1,176	43%	8,868	15,649
<input type="checkbox"/> West	112,355	81%	7,291	6,774	92%	11,772	138,042
<input type="checkbox"/> Anglesey	43,414	81%	3,555	2,252	91%	4,626	53,796
<input type="checkbox"/> Arfon	34,863	80%	2,986	2,452	92%	3,528	43,798
<input type="checkbox"/> Dwyfor	22,174	83%	739	1,387	91%	2,306	26,562
<input type="checkbox"/> Meirionnydd	11,904	86%	11	683	91%	1,312	13,886
<input type="checkbox"/> Centre	118,183	78%	20,978	6,847	96%	6,244	152,056
<input type="checkbox"/> Central & South Denbighshire	24,525	82%	3,081	1,133	96%	1,287	29,996
<input type="checkbox"/> Conwy East	28,098	77%	6,350	1,454	98%	732	36,566
<input type="checkbox"/> Conwy West	35,894	78%	6,622	2,164	98%	1,187	45,810
<input type="checkbox"/> North Denbighshire	29,666	75%	4,925	2,096	92%	3,038	39,684
<input type="checkbox"/> East	158,871	79%	12,808	14,678	92%	16,062	202,165
<input type="checkbox"/> Central Wrexham	26,516	72%	5,333	2,475	94%	2,417	36,666
<input type="checkbox"/> North & West Wrexham	20,353	81%	2,284	1,885	98%	489	24,979
<input type="checkbox"/> North East Flintshire	31,695	77%	1,809	3,003	89%	4,678	41,150
<input type="checkbox"/> North West Flintshire	20,228	76%	2,159	2,463	93%	1,881	26,693
<input type="checkbox"/> South Flintshire	30,489	83%	1,108	2,137	92%	3,023	36,725
<input type="checkbox"/> South Wrexham	29,590	82%	115	2,715	90%	3,574	35,952
Total	389,412	78%	40,898	29,144	92%	41,916	500,773

Booster Uptake by Cluster

Booked Vaccinated Cancelled Unbooked

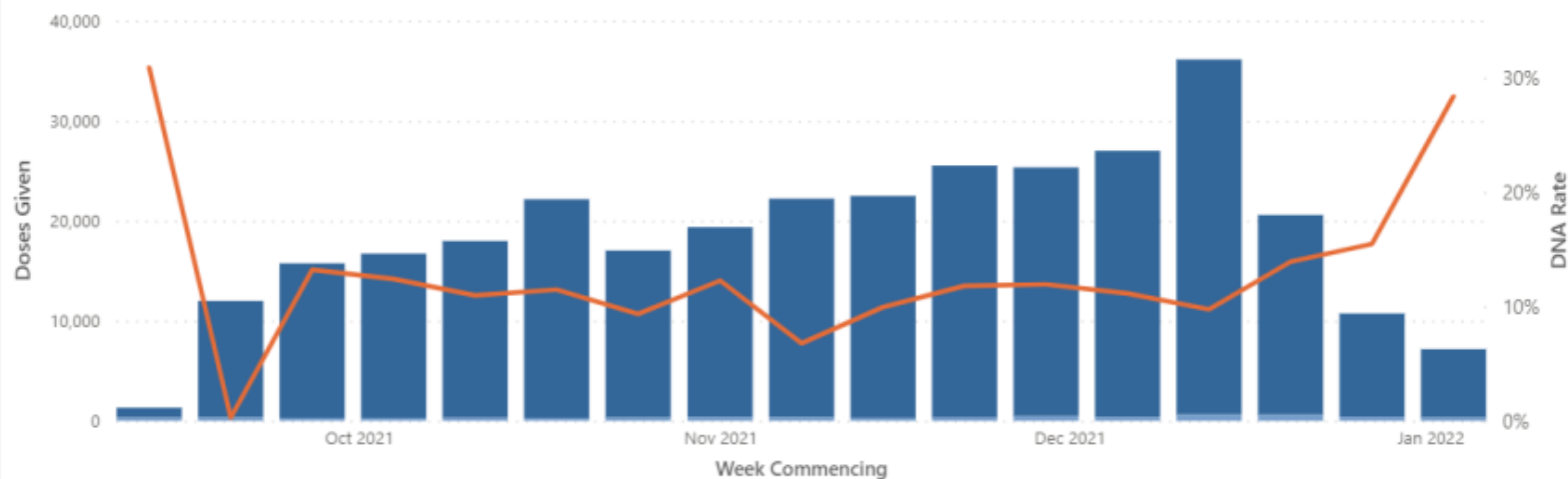


Booster DNA/CNA Data by Priority Group – to 10/01/22

(Data extract 08:27 hrs 10/01/22)

Weekly DNA Rates | Doses given by programme phase provided for reference

Programme Phase ● Phase 1 ● Phase 2 ● DNA Rate



Total Appointments

477,617

Doses Given

319,471

DNA

41,474

CNA

115,616

Att - Not Given

1,056

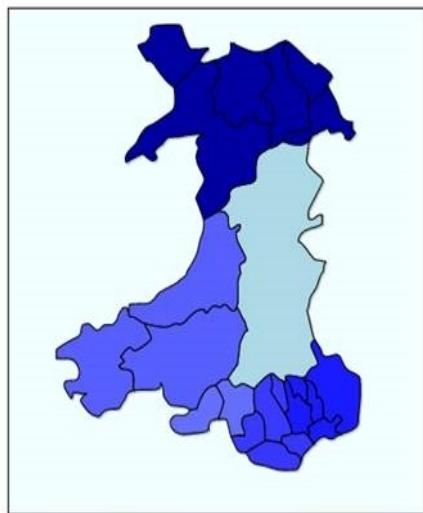
Outcome by Priority Group

Outcome	P1.1	P1.2	P2.1	P2.2	P2.3	P3	P4.1	P4.2	P5	P6	P7	P8	P9
CNA	138	4,113	13,834	7,325	3,965	9,141	11,636	3,391	9,451	22,750	7,885	9,916	12,071
DNA	43	2,723	4,947	4,353	1,995	2,320	2,654	1,709	2,431	10,329	1,888	2,764	3,318
Given	5	3,451	9,267	33,448	22,757	8,360	28,321	39,362	9,900	33,231	59,268	21,528	24,291
Not Given	30	33	117	97	34	82	106	39	88	212	61	81	76

BCU Local Authority Comparison Data – to 10/01/22

(Data extract 10:27 hrs 10/01/22)

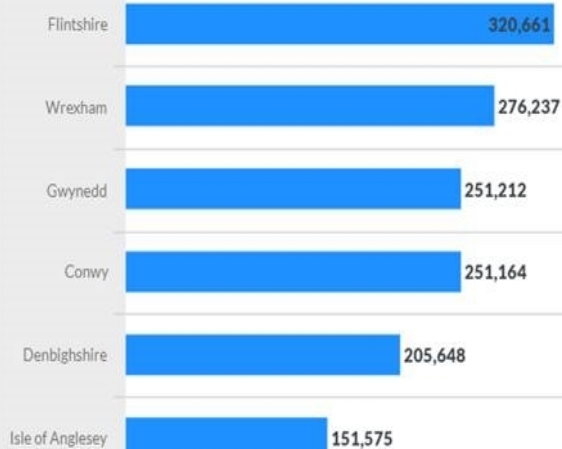
By Health Board of Residence - All Doses



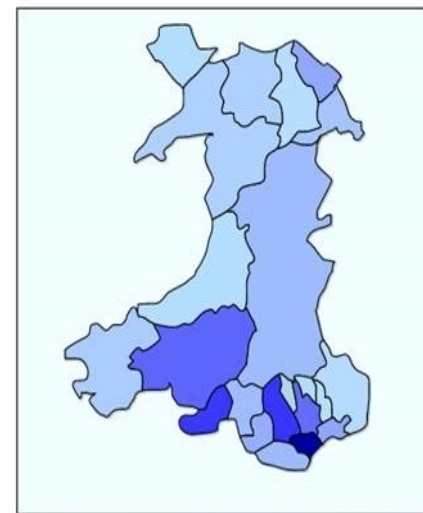
292443 Vaccinations 1456497

Vaccinations Given by Local Authority of Residence (Cumulative)

Betsi Cadwaladr UHB - All Vaccines - All Location Types - All Doses



By Local Authority of Residence - All Doses

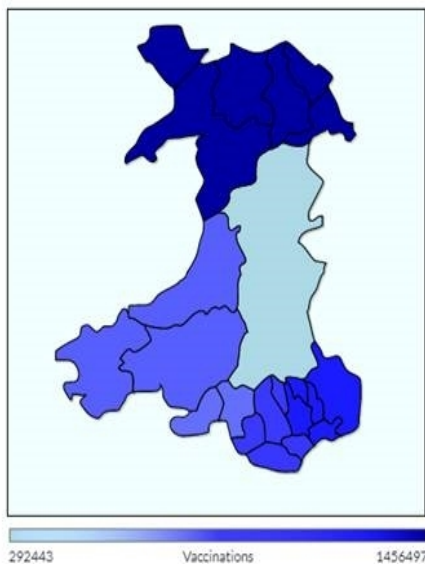


127671 Vaccinations 737931

All Wales Health Board Booster - 10/01/22

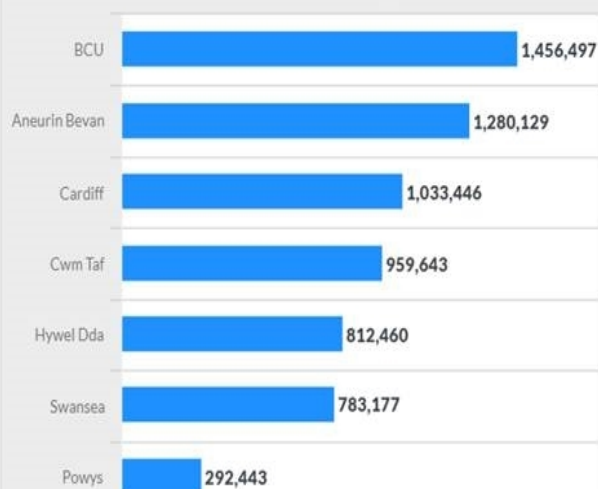
(Data extract 10:27 hrs 10/01/22)

By Health Board of Residence - All Doses

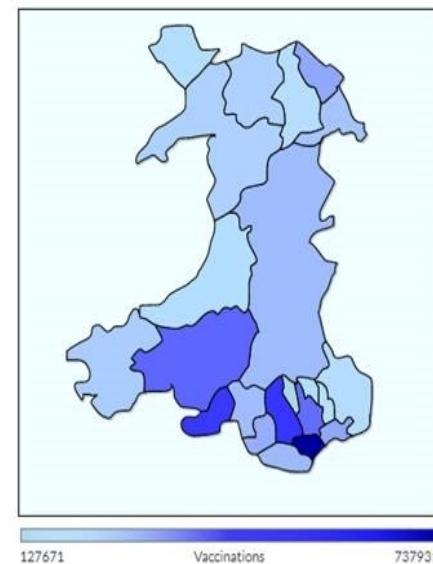


Vaccinations Given by Health Board of Residence (Cumulative)

Wales - All Vaccines - All Location Types - All Doses



By Local Authority of Residence - All Doses



New Risks – 2

1. 4256 - Vaccine Expiry Dates – Scoring 20
2. 4257 - Vaccinating 5 – 11 Year Olds – Scoring 16

Reduced Risks – 12

1. 4067 Covid-19 variant outbreak impacts on the Booster Vaccination Programme – Reduced to Target & Monitor
2. 4216 Delivery of the Enhanced Vaccination Programme from WG – Reduced to Target & Monitor
3. 4247 Workforce to be Redeployed within the HB to support the Vaccination Programme – Reduced to Target & Monitor
4. 4047 Workforce to deliver the Booster Programme – Reduced to Target & Monitor
5. 4221 BCU Info Email Inbox Account – Reduced to Target & Monitor
6. 4064 Booster Vaccination Programme - Security Threat – Reduced to 12
7. 4137 Lone Working & Security Guards when Returning Vaccine on Sites– Reduced to 12
8. 4069 Booster Programme Vaccine Accessibility - Reduced to Target & Monitor
9. 4149 NWSSP Timescale to Recruitment & the Process – Reduced to 12
10. 4237 Welsh Government request for Vaccine Stock Checks – Reduced to 8
11. 4148 Loss of Public Confidence and the impact of the HBs public image – Reduced to 10

Closed Risks – 5

1. 4059 Booster Vaccination programme planning
2. 4246 Office 365 Online Booking Service
3. 4123 Senior Leads Annual Leave Planning
4. 4104 Staff Contract Extensions for Booster Programme
5. 4052 WIS Updates to include Booster Programme

Booster Programme Risks

Those currently scoring 12 and above

ID	Handler	Manager	Title	Description	Controls in place	Risk Rating (current)	Risk Rating (Target)
4256	Spruce, Miss Katie	Rustom, Mr Graham	Vaccine Expiry Dates	<p>There is a risk that large amounts of Vaccine will expire prior to utilisation.</p> <p>This is due to WG advising BCU to order vaccine based on a 100% uptake, in line with WG target of the end of December 2021. Large quantities of the vaccine will expire in January 2022.</p> <p>This could impact the Vaccination Programme as work will need to be carried out to relocate the vaccine within the Health Board.</p>	<p>1. Focus needs to be on escalation of approaching expiry dates to pharmacy leads and mobilisation of existing stock over ordering further.</p> <p>2. Discussions are taking place with Pharmacy colleagues in South Wales and WG.</p>	20	4
4122	Spruce, Miss Katie	Rustom, Mr Graham	Long Term Vaccination Programme Solutions	<p>There is a risk that we may not be able to plan effectively from March 2022 onwards if we do not receive guidance from Welsh Government.</p> <p>This could impact the programme progressing effectively from March 2022 if we do not receive guidance from WG in the near future.</p> <p>This could cause delays for our citizens and planning.</p>	<p>1. Programme recognises the risk of the long term future requirements and have put the questions to WG.</p>	16	4
4257	Spruce, Miss Katie	Rustom, Mr Graham	Vaccinating 5 - 11 Year Olds	<p>There is a risk of not being able to completed the two dose programme for 5-11 year olds due to the restricted time frame given by the vaccine expiry date.</p> <p>The vaccine doses 1 and 2 will arrive on the 19th January 2022 to the UK and must be utilised by 30th April 2022.</p> <p>An 8 week interval between 1st and 2nd doses is required.</p>	<p>1. Planning is underway to deliver.</p>	16	4

Booster Programme Risks

Those currently scoring 12 and above

4064	Spruce, Miss Katie	Rustom, Mr Graham	Booster Vaccination Programme - Security Threat	Intelligence from partner organisations suggests that there is a risk that unknown individuals or groups could threaten or attack the personal safety, equipment safety or location safety of BCUHB staff and equipment involved in delivering the COVID19 vaccination programme at either Mass Vaccination sites or Local Vaccination Sites.	<ol style="list-style-type: none"> 1. We have scheduled regular Liaison with North Wales Police via our BCUHB Security Advisors to receive Intelligence reporting on the veracity of the threat. NWP have visited each of our MVCs and have advised on improvements where necessary and agreed that our security provision is adequate and appropriate. NWP Observed additional solutions have been implemented. 2. We have developed an internal SOP to give direction on reactions to be implemented in regard to security breaches by threat level. 3. We have an agreed process of support for Mass Vaccination Centres with External Partners to Implement Security Management mitigations. 4. We have agreed a process of regular review of the security threat and potential escalation contingencies. 	12	4
4137	Spruce, Miss Katie	Rustom, Mr Graham	Lone Working & Security Guards when Returning Vaccine on Sites	<p>There is a risk that staff members could be transporting vaccine on sites individually due to minimal security on site. This is caused by security guards not turning up for shifts in the evening and a break in communication between the security and vaccination teams.</p> <p>This could impact staff members safety and the programme losing vaccine if approached by unknown individuals.</p>	<ol style="list-style-type: none"> 1. Security on all sites every evening and night. 2. Security to escort staff members carrying vaccine to storage. 	12	4
4149	Spruce, Miss Katie	Rustom, Mr Graham	NWSSP Timescale to Recruitment & the Process	<p>There is a risk that newly recruited staff may not commence employment in a quick and timely manner.</p> <p>There is a risk that NWSSP do not have the workforce to assist in the processing applications in mass. This is due to the constraints NWSSP have in relation to their own staffing levels and the demand of NAFs and Payroll submissions.</p> <p>This is caused by the need for rolling Workforce on all vaccination sites, caused by staff leaving for alternative employment or returning to substantive positions.</p> <p>This is also caused by extra demands for the programme from Welsh Government.</p> <p>This could impact on the Booster Programme as staff may not take up employment due to the lengthy process.</p>	<ol style="list-style-type: none"> 1. Fast track process through NWSSP. 2. NWSSP working at full capacity to push through NAFs. 3. HR support is being recruited into each of the areas to assist. 	12	4



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 11 th January 2022
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Corporate Risk Register Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Simon Evans-Evans, Interim Director of Governance
Awdur yr Adroddiad Report Author:	Justine Parry, Assistant Director: Information Governance and Risk
Craffu blaenorol: Prior Scrutiny:	Risk Management Group Chairs Action Approval on the 14 th December 2021 Executive Team on the 22 nd December 2021
Atodiadau Appendices:	Appendix 1 – CRR Report for QSE Appendix 2 – Full List of Corporate Risks Appendix 3 – Risk Key Field Guidance
Argymhelliad / Recommendation:	
That the Committee:-	
<p>1. Note the Risk Management Group was stood down on the 13th December 2021 to allow Gold Command and the vaccination management to be progressed.</p> <p>2. Note the Risk Management Group Chair's Actions process was followed to approve the risks for presentation to the Executive Team, before onward presentation to Board Committees.</p> <p>3. Note the Key Field Guidance Document has been updated following Audit Committee members feedback and is attached as Appendix 3.</p> <p>4. Review and note the progress on the Corporate Tier 1 Operational Risk Register Report as set out below and in detail at Appendix 1:</p> <p>CRR20-01: Asbestos Management and Control</p> <p>a) Note the Executive Team (ET) recognise the progress in implementing actions including the action plan in response to the Internal Audit Report, ahead of the deadline date as well as two further controls put in place to cover testing, monitoring and removal of high risk asbestos programmes.</p> <p>b) Note the completion of the Action ID18298, approved by ET, so that it will be archived and removed from the next report, recognising that its implementation will be captured as part of the controls within the next iteration of the risk.</p> <p>c) Note the additional Action ID19758 to provide asbestos management legislative compliance validation and assurance which in turn will further support risk mitigation.</p> <p>CRR20-02: Contractor Management and Control</p> <p>a) Note the ET recognise the progress in implementing actions in line with the identified timeframes which remain on track including the strengthening of the evaluation process to monitor contractor performance and oversight.</p> <p>b) Note the additional Action ID19759 to address the resource gap identified which in turn will further support risk mitigation.</p>	

CRR20-03: Legionella Management and Control

- a) **Note** the ET recognise the progress in implementing actions which includes addressing previous gaps identified with regards to the weakness in pipe work alterations and these now being authorised.
- b) **Note** a request from Audit Committee to clarify if the risk covers staff operating from non-BCU premises, which will be considered and addressed as part of the next iteration of the risk.
- c) **Note** the additional Actions ID19760 and 19761 to address the gaps identified and to further strengthen the controls in place to reduce the likelihood of the risk materialising.
- d) **Note** the extension to the due dates for Action ID12268 was rejected by ET requesting further clarification as to whether the action was now complete.
- e) **Note** the extension to the due date for Action ID19015 to allow time for recruitment processes to be completed following approval of the business case.

CRR20-04: Non-Compliance of Fire Safety Systems

- a) **Note** the ET recognise the progress in implementing actions which includes undertaking proposed works in a timely manner following the funding received from EFAB and Statutory compliance to support the risk mitigation and the completion and implementation of the governance actions following the Internal Audit on Fire Systems, ahead of the anticipated completion date.
- b) **Note** the Estates and Facilities Team are activity awaiting the release of new legislation following the outcomes of the Grenfell Enquiry so that BCUHB are sighted and pro-active on any potential impact on the Health Board.
- c) **Note** the completion of the Action ID12273, approved by ET, so that it will be archived and removed from the next report, recognising that its implementation will be captured as part of the controls within the next iteration of the risk.

CRR20-05: Timely access to care homes

- a) **Note** the ET recognise the progress in groups continuing to meet as part of the Quality Assurance Framework and engagements with the sector. Also recognising the standardisation of the Framework and Performance reporting across North Wales.
- b) **Note** the extension to the due date for Action ID18025 to allow time for the Regional Board to mandate the proposal.
- c) **Note** the additional Action ID20074 to address the gap identified and to further support risk mitigation.
- d) **Note** the applied extension to the target risk due date following approval at the Committee on the 2nd November 2021.

CRR20-08: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.

- a) **Note** the ET recognise the progress in implementing actions including the implementation of a new contract to outsource activity.
- b) **Note** the additional Action ID20392 address the gap for additional Intra Vitreal Therapy capacity with regards to recruitment of posts.
- c) **Note** the applied extension to the target risk due date following approval at the Committee on the 2nd November 2021.

CRR21-13: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)

- a) **Note** the ET recognise the progress in recruitment for both permanent and temporary workforce and are mindful the impact on the management of the pandemic is currently having on the ability to reduce this risk.

- b) **Note** the update to the Staffing Act to now include paediatric inpatient areas since the 1st October 2021, which is being addressed as part of this risk.
- c) **Note** a request from Audit Committee to revise the controls with specific reference to Strategies in place, which will be considered and addressed as part of the next iteration of the risk.
- d) **Note** the further extension to the due date for Action ID17509 was rejected by ET requesting further clarification.
- e) **Note** the completion of the Action ID17508, approved by ET, so that it will be archived and removed from the next report, recognising that its implementation will be captured as part of the controls within the next iteration of the risk.
- f) **Note** the additional Action ID20039 to embed the impact of the Safe Staffing Act into the Health Board's business planning cycle which will support future proofing the risk and increase the controls in place to reduce the risk score.

CRR21-14: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients

- a) **Note** the applied extension to the target risk due date following approval at the Committee on the 2nd November 2021.
- b) **Note** the clarification regarding the inherent risk score being lower than the current risk score due to the unforeseen significant increase in activity (44%).
- c) **Note** the ET recognise the progress in the management of the risk including the implementation of the Strategic Implementation Task Group for Liberty Protection Safeguards and the successful Welsh Government bid for Mental Capacity Act training and to support addressing the Deprivation of Liberty Safeguards backlog activity.
- d) **Approve** a request from the Mental Health Act Committee to transfer this request for future oversight by this Committee instead of QSE.
- g) **Note** the completion of the Actions ID15704, 15706 and 15707 following clarification from the ET on the approval of the business case, so that they will be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.
- e) **Note** the extension to the due date for Actions ID15708 and 18118 was rejected by ET requesting further clarification.

CRR21-15: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014

- a) **Note** the ET recognise the progress in the management of the risk including the updating of the gaps and the mitigations required to address those gaps and the successful implementation of the two independent advocate posts for health across two regions.
- b) **Note** the completion of the Actions ID15701, 15702 and 18115 following clarification from the ET on the approval of the business case, so that they will be archived and removed from the next report, recognising that their implementation will be captured as part of the controls within the next iteration of the risk.

CRR21-16: Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients

- a) **Note** the ET recognise the difficulty experienced with regards to management of this risk, recruitment to posts during the pandemic and the alternative measures being put in place to increase training capacity and compliance.
- b) **Note** the extension to the due date for Actions ID17978, ID17979 and ID17980 was rejected by ET requesting further clarification for the time extensions.

CRR21-17: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours

- a) **Note** the applied extension to the target risk due date following approval at the Committee on the 2nd November 2021.
- b) **Note** the ET recognise the progress in the management of the risk including the continued conversation with Welsh Government to pilot the use of safe spaces to address the identified gap.
- c) **Note** the extension to the due date for Action ID17961 was rejected by ET, requesting further clarification. Two out of the three regions have submitted their risk assessments with the remaining area being contacted. As soon as confirmation on completion of the final assessment has been undertaken, this action can be closed.
- d) **Note** the additional Actions ID19594 and 19595 to strengthen assurance processes which will support risk mitigation and reduce the risk score.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

The Corporate Risk Register (CRR) demonstrates how the Health Board is robustly mitigating and managing high rated risks to the achievement of its operational objectives.

The design of both the Board Assurance Framework (BAF) and CRR emphasises their distinctive roles in underpinning the effective management of both strategic and operational risks respectively, as well as underlining their symbiotic relationship as both mechanisms have been designed to inform and feed-off each other, the BAF is reported separately.

Each Corporate Risk has been reviewed and updated. The full CRR will next go to the Board in January 2022.

Cefndir / Background:

The implementation of the revised Risk Management Strategy underlines the Health Board's commitment to placing effective risk management at the heart of everything it does while embedding a risk-based approach into its core business processes, objective setting, strategy design and better decision making. The CRR reflects the Health Board's continuous drive to foster a culture of constructive challenge, agile, dynamic and proactive management of risks while encouraging staff to regularly horizon scan for emerging risks, assess and appropriately manage them.

Teams reporting to the Lead Director (who is the Senior Responsible Officer for the risk) locally own and manage risks with support from the corporate risk team. The Risk Management Group has oversight of all risks and is scrutinised by the Executive Team who make the proposals for changes to the CRR to Board and Committees.

Following a previous QSE meeting recommendation, further work is continuing to finalise and approve the anticipated new risk in relation to the Health Boards resilience to uncertainty, unknowns and

potential uncharted territory which could be caused by a number of converging and novel factors. The risk has been assigned to the Executive Director of Primary and Community Services as it is linked to business continuity and emergency planning.

Summary Table of the Full Corporate Tier 1 Risk Report:

Current Tier 1 Risks for the Quality, Safety and Experience/Performance Committee oversight (full details and progress can be found in Appendix 1):

Risk Title	Inherent risk rating	Current risk rating	Target risk rating	*Movement
CURRENT RISKS – Appendix 1				
CRR20-01 - Asbestos Management and Control	20	15	8	Decreased
CRR20-02 - Contractor Management and Control	20	15	8	Decreased
CRR20-03 – Legionella Management and Control	20	16	8	Decreased
CRR20-04 - Non-Compliance of Fire Safety Systems	20	16	8	Decreased
CRR20-05 – Timely access to Care Homes	25	20	6	Unchanged
CRR20-08 – Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	25	20	6	Unchanged
CRR21-13 - Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	20	16	6	Unchanged
CRR21-14 - There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	25	20	6	New Risk, will be presented to the Board in January 2022
CRR21-15 – There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014.	20	16	12	New Risk, will be presented to the Board in January 2022

CRR21-16 – Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients.	20	16	4	New Risk, will be presented to the Board in January 2022
CRR21-17 - The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	20	16	8	New Risk, will be presented to the Board in January 2022

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

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

Current Risk Level		Impact				
		Very Low - 1	Low - 2	Moderate - 3	High - 4	Very high - 5
Likelihood	Very Likely - 5				CRR21-14	
	Likely - 4				CRR20-03 CRR20-04 CRR21-13 CRR21-15 CRR21-16 CRR21-17	CRR20-05 CRR20-08
	Possible - 3					CRR20-01 CRR20-02
	Unlikely - 2					
	Rare - 1					

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

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

Opsiynau a ystyriwyd / Options considered

Continuing with Corporate Risk Register.

Goblygiadau Ariannol / Financial Implications

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

Dadansoddiad Risk / Risk Analysis

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

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

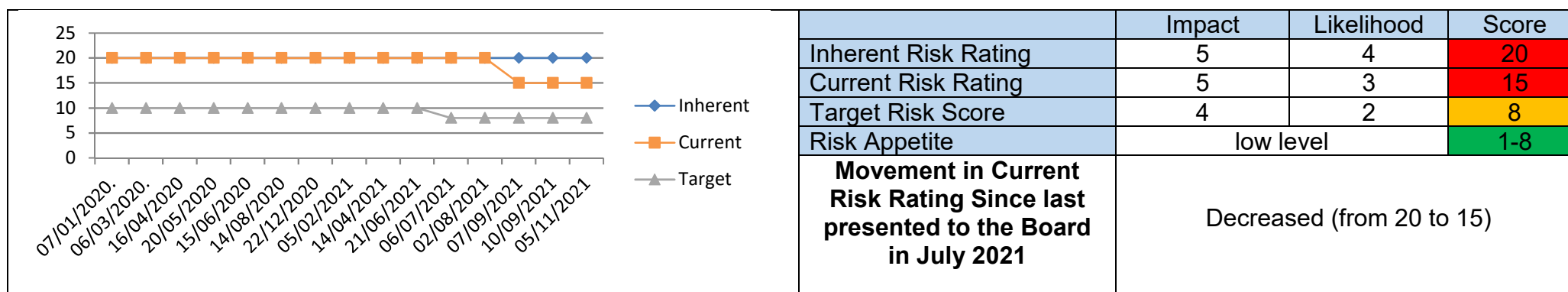
There are no legal and compliance issues associated with the delivery of the Risk Management Strategy and Policy.

Asesiad Effaith / Impact Assessment

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

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

CRR20-01	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 05 November 2021
	Risk: Asbestos Management and Control	Date of Committee Review: 02 November 2021
		Target Risk Date: 31 March 2022
There is a significant risk that BCUHB is non-compliant with the Asbestos at Work Regulations 2012. This is due to the evidence that not all surveys have been completed and re-surveys are a copy of previous years surveys. There are actions outstanding in some areas from surveys. This may lead to the risk of contractors, staff and others being exposed to asbestos, and may result in death from mesothelioma or long term ill health conditions, claims, HSE enforcement action including fines, prosecution and reputation damage to BCUHB.		



Controls in place	Assurances
<ol style="list-style-type: none"> Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group. Annual programme of re-inspection surveys undertaken. An independent audit of internal asbestos management system completed by an independent UCAS accredited body. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group. Asbestos register available. Targeted surveys where capital work is planned or decommissioning work undertaken. An annual training programme for operatives in Estates is in place. Air monitoring undertaken in premises where there is limited clarity on asbestos condition. 5 year programme for the removal of high risk asbestos with monitoring at the asbestos group is in place with oversight at the strategic health and safety group. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework. 	<ol style="list-style-type: none"> Health and Safety Leads Group. Strategic Occupational Health and Safety Group. Quality, Safety and Experience Committee. Internal Audit review undertaken against the gap analysis. Self-assessment completed and submitted to WG which use specialist services to review the returns for consistence and compliance.

Gaps in Controls/mitigations

1. Significant progress has been made in terms of training and compliance with further work ongoing, further delay is due to long term staff absences. 95% compliance target is to be achieved by the 31/3/2022, it is felt that due to staff absences 100% compliance is not achievable.

Progress since last submission

1. Controls in place strengthened including the completion of an audit by an independent and accredited body. Two further controls have also be added which cover the testing, monitoring and removal of high risk asbestos programme.
2. Gaps in controls has been reviewed and updated to align with current risk position
3. Significant work has been undertaken to increase the training compliance, with 86% compliance achieved to date for asbestos awareness, with 83% compliance on the higher level duty to manage asbestos training course.
4. Assurances have been strengthened to include the external specialist review of the Health Board's WG self-assessment return.
5. Action ID 18298 – Proposal to close this action as the action plan is now in place ahead of the anticipated completion date.
6. An Additional action has been identified to provide validation and a level of assurance in terms of compliance with legislation in relation to asbestos management to support the reduction in the risk score.

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

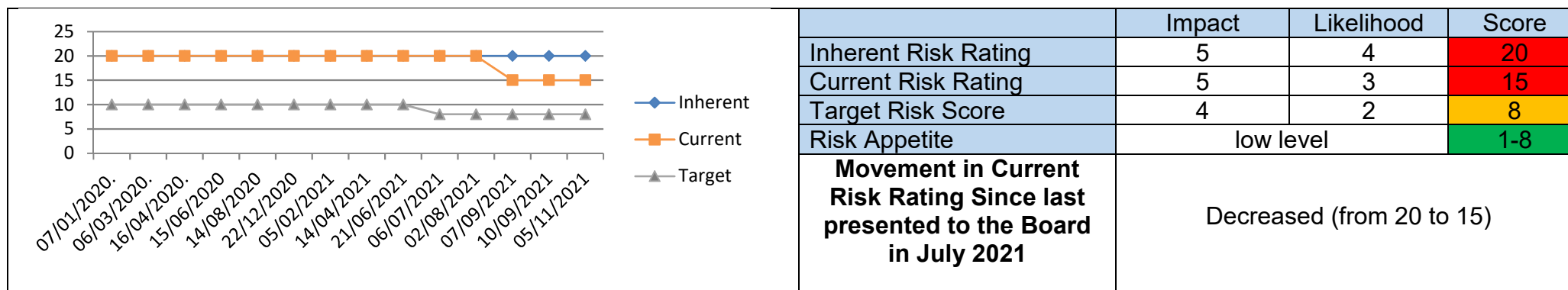
Strengthen our wellbeing focus
Making effective and sustainable use of resources (key enabler)

BAF21-13
BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12243	Review schematic drawings and process to be implemented to update plans from Safety Files etc. This will require investment in MiCad or other planning data system.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	This action will help us to identify the areas of asbestos and thus better mitigate and manage any potential impact by enabling to a web supported system to access records remotely.	On Track

	12248	Update intranet pages and raise awareness with staff who may be affected by asbestos.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Creating staff awareness of the presence of asbestos thus reducing any potential impact.	On Track
	18298	To develop and implement a Management Action Plan in response to the Internal Audit report.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	02/11/2021 - Action closed ahead of time and request closure of action approval. The Management Action Plan will support current mitigation and management of the risk.	Completed
	18686	Ensure 100% compliance with asbestos awareness training for Operational Estates maintenance staff.	Mr Arwel Hughes, Head of Operational Estates - Interim	31/03/2022	Ensure compliance with training legislation and help to reach the target risk score.	On Track
	19758	Undertake audits by the independent asbestos consultant to audit compliance with legislation and provide assurance in relation to asbestos management.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Provide a level of assurance in terms of compliance with legislation and provide assurance in relation to asbestos management to validate compliance and support the reduction in the risk score.	On Track

CRR20-02	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 05 November 2021
	Risk: Contractor Management and Control	Date of Committee Review: 02 November 2021
		Target Risk Date: 30 September 2022
There is a risk that BCUHB fails to achieve compliance with Health and Safety Legislation due to lack of control of contractors on sites. This may lead to exposure to substances hazardous to health, non compliance with permit to work systems and result in injury, death, loss including prosecution, fines and reputation damage.		



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

Gaps in Controls/mitigations
<ol style="list-style-type: none"> Lack of ongoing programme of training in line with requirements in legislation. It is recognised that the existing estates management capacity is often exceeded by the number of projects and capital works that is in progress and is therefore is a limiting factor.

Progress since last submission

1. Controls in place strengthened including the evaluation process to monitor contractor performance and oversight reporting to the Occupational Health and Safety Strategic Group.
2. Action ID 12254 – Proposal to close this action as Operational Estates have included an extract from the NHS Procurement Services procedure as part of the 'CONTRACTORS SAFETY GUIDANCE DOCUMENT' to ensure that all small works contractors acknowledge the requirement and standards set out within the Health Board. This action has been completed ahead of the deadline date.
3. An additional action has been identified to secure funding for additional authorised/competent persons to mitigate the resource gap.

Links to

Strategic Priorities

Strengthen our wellbeing focus

Principal Risks

BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12252	Identify service Lead on each site to take responsibility for Contractors and H&S Management within H&S Policy).	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for additional staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track

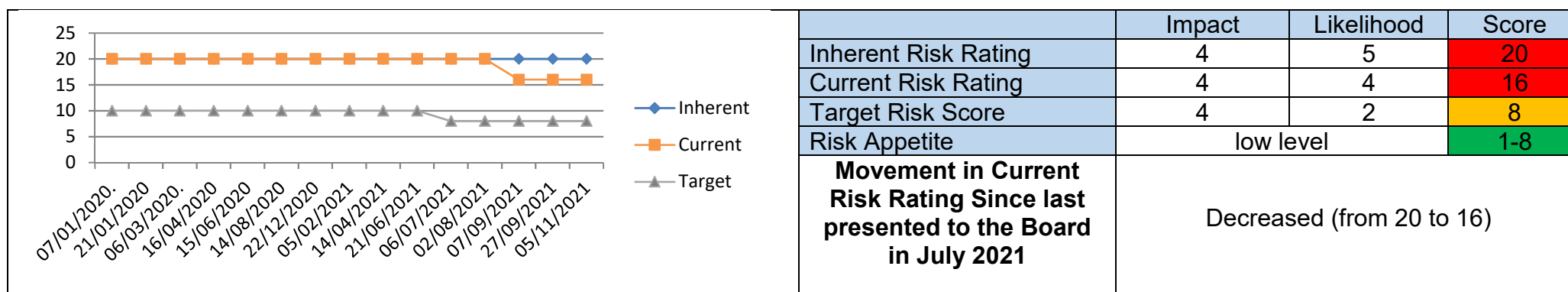
	12254	Identify current tender process & evaluation of contractors, particularly for smaller contracts consider Contractor Health and Safety Scheme on all contractors. This will ensure minimum H&S are implemented and externally checked prior to coming to site.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	<p>ACTION CLOSED 05/11/2021 - Action closed ahead of the action due date.</p> <p>Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance for contractor's appointment criteria. The process and system will be a Health Board wide management system.</p> <p>Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.</p>	Completed
	12255	Evaluate the current assessment of contractor requirements in respect of H&S, Insurance, competencies etc.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	<p>Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.</p> <p>Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.</p>	On Track
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE data base.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	<p>Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board.</p> <p>Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.</p>	On Track

	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track
	12258	Identify responsible person to review RA's and signs off Method Statements (RAMS), skills, knowledge and understanding to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.	On Track

					Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	
	12259	Identify the current Permit To Work processes to determine whether is it fit for purpose and implemented on a pan BCUHB basis.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	<p>A Permit to Work system will be adopted as part of implementation of SHE software.</p> <p>Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.</p>	On Track
	12260	Lack of consistency and standardisation in implementation of contractor management procedure picked up in H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/05/2022	<p>Implementation of 'Management of Contractor' software (SHE) will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. NB – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, IMT and Radiology etc. An additional work stream will be required to by these divisions to ensure compliance with contractor management across the Health Board.</p> <p>Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.</p>	On Track

	12552	Induction process to be completed by all contractors who have not yet already undertaken.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Resources within Operational Estates have been reviewed as part of the Corporate Health and Safety gap analysis. The resources business case has identified a requirement for addition staff resources to support the current management structure. Service based Health and Safety team leaders will be appointed with each of the Operational Estates geographical areas to manage COSHH and Inspection process to ensure compliance.	On Track
	18688	An annual review of business as usual capacity to be developed to ensure estates project management capacity is not exceeded.	Mr Arwel Hughes, Head Of Operational Estates - Interim	31/03/2022	Create assurance that there is sufficient estates management capacity and technology to ensure that projects can be delivered safely.	On Track
	19759	Funding to be secured for additional authorised/competent persons to mitigate the resource gap.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	A revenue business case for additional authorised/competent persons has been prepared and has been put forward for financial/resource consideration on a recurrent basis and will address the gap identified and support the reduction in the risk score to achieve the target.	On Track

CRR20-03	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 05 November 2021
	Risk: Legionella Management and Control	Date of Committee Review: 02 November 2021
		Target Risk Date: 30 September 2022
There is a significant risk that BCUHB is non-compliant with COSHH Legislation (L8 Legionella Management Guidelines). This is caused by a lack of formal processes and systems, to minimise the risk to staff, patients, visitors and General Public, from water-borne pathogens (such as Pseudomonas). This may ultimately lead to death, ill health conditions in those who are particularly susceptible to such risks, and a breach of relevant Health & Safety Legislation.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Legionella and Water Safety Policy in place. 2. Risk assessment undertaken by clear water. 3. High risk engineering work completed in line with clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by clear water. 5. Water samples taken and evaluated for legionella and pseudomonis. 6. Authorising Engineer water safety in place who provides annual report. 7. Annual Review of the H&S Self Assessments undertaken by the Corporate H&S Team. 8. Water safety Group has been established to better provide monitoring, oversight and escalation. 9. Internal audit of compliance checks for water safety management regularly undertaken. 10. Alterations to water systems are now signed off by responsible person for water safety. 	<ol style="list-style-type: none"> 1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Experience Committee.

Gaps in Controls/mitigations
<ol style="list-style-type: none"> 1. There is a weakness that little used outlets are not reported to Estates for management and control. e.g. we can have a ward shower temporarily used as a store, therefore it isn't part of Estate flushing programme. 2. BCU wide Water safety plan is currently being written, which will provide legal requirement under L8 for processes and controls for water safety systems to be completed by the 31/12/2021.

3. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case is currently unfunded and provides supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety.

Progress since last submission

1. Additional controls added to address the previous gap identified with regards to the weakness in pipe work alterations being authorised.
2. Gaps in controls reviewed and updated to align with current risk position.
3. An additional action has been identified, action ID 19760 to confirm that the HB has an appointed authorising engineer for water safety.
4. An additional action has been identified, action ID 19761 to improve on the consistent reporting and identification of little used outlets in both community and acute settings.
5. Action ID 12268 - Proposal to extend the action due date was rejected by ET, further confirmation and clarification as to whether the action is now completed is required and will be addressed within the next iteration of the risk.
6. Action ID 19015 - Proposal to extend the action due date from the 31/12/2021 to the 31/03/2022 to allow time to secure funding and deliver on the recruitment processes as per the business case.

Links to

Strategic Priorities

Making effective and sustainable use of resources (key enabler)
Strengthen our wellbeing focus

Principal Risks

BAF21-13
BAF21-17

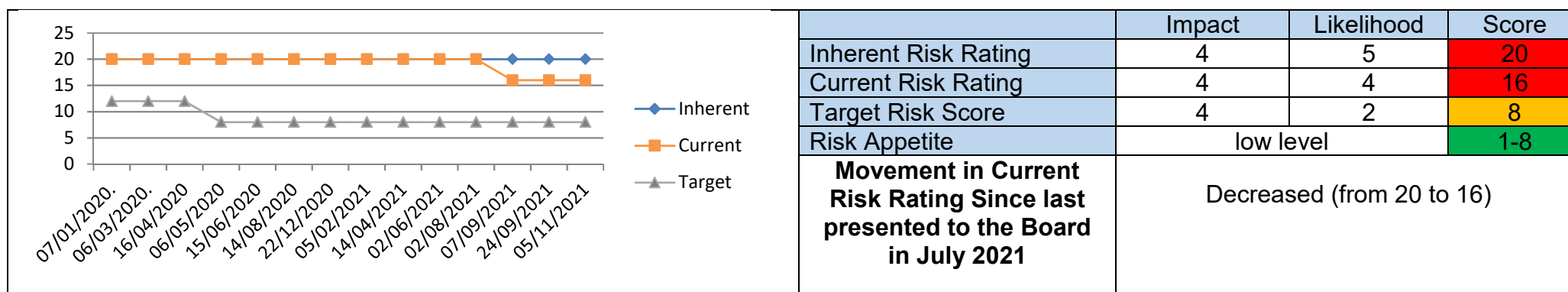
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up to date under Estates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

	12263	Departments to have information on all outlets and deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk.	On Track
	12264	Departments to have a flushing and testing regime in place, defined in a Standard Operating Procedure, with designated responsibilities and recording mechanism Ward Manager or site responsible person.	Mr Rod Taylor, Director of Estates & Facilities	30/06/2022	A policy for the Management of Safe Water Systems in place to ensure water safety compliance. A programme of flushing of little use outlets in place for un-occupied areas and recorded by Operational Estates for each site.	On Track
	12265	Water quality testing results and flushing to be logged on single system and shared with or accessible by departments/services - potential for dashboard/logging system (Public Health Wales).	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	Pseudomonas and Legionella sample testing carried out within augmented care areas, exception reports are presented at the Water Safety Group in an excel format. All water testing across BCUHB is undertaken by Operational Estates through Public Health Wales.	On Track
	12266	Standardised result tracking, escalation and notification procedure in place, with appropriate escalation route for exception reporting.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Escalation and notification process is contained within Policy for the Management of Safe Water Systems (Appendix B).	On Track
	12267	Awareness and training programme in place to ensure all staff aware. Departmental Induction Checklist.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	A training and development structure for Operational Estates is being reviewed as part of new Water Safety Contract, which has just been approved by the Health Board.	On Track

	12268	BCUHB Policy and Procedure in place and ratified, along with any department-level templates for SOPs and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	<p>A policy for water safety management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document.</p> <p>As part of the water safety plan infection prevention will need to be integrated within key sections of the plan.</p> <p>Request extension to due date to 23/12/2021.</p> <p>Extension to due date not approved at Executive Team 22/12/2021.</p>	Delay
	12270	Lack of consistency and standardisation in the implementation of the Legionella and Water Safety Policy picked up in the H&S Gap Analysis Action Plan.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Independent Consultant appointed to review the current procedural documents for each area with the objective to develop one policy document.	On Track
	19015	Secure funding and appointment of 3x band 7 Senior estates officers for water safety.	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	<p>Provide resources to be able to manage safe water systems and have the facility to carry out departmental audits on water safety and provide assurance of compliance to the water safety group.</p> <p>Request extension to due date to 31/3/2022, this will allow time to secure funding and to deliver the recruitment process.</p>	Delay

	19760	Confirmation that the HB has an appointed authorising engineer for water safety, a function that is provided by NHS shared services (specialist estates services).	Mr Rod Taylor, Director of Estates & Facilities	31/12/2021	Provide and independent water safety specialist engineer to ensure HB is compliance in its duties in terms of Water safety, which in turn will increase controls and support the reduction in the likelihood of the risk materialising.	On Track
	19761	Improve on the consistent reporting and the identification of little used outlets in both community and acute settings.	Mr Arwel Hughes, Head of Operational Estates - Interim	28/02/2022	This action will support and substantiate the adjusted lower risk score that has been signed off at committee.	On Track

CRR20-04	Director Lead: Executive Director of Finance	Date Opened: 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 05 November 2021
	Risk: Non-Compliance of Fire Safety Systems	Date of Committee Review: 02 November 2021
		Target Risk Date: 30 September 2022
There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant backlog of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Fire risk assessments in place. 2. Escape routes identified and evacuation drill undertaken, established and implemented. 3. Fire Safety Policy established and implemented. 4. Fire Engineer regularly monitor Fire Safety Systems. 5. Fire Safety Mandatory Training and Awareness session regularly delivered to BCUHB Staff. 6. Fire Warden Mandatory Training established and being delivered to Nominated Fire Warden. 7. Annual Fire Safety Audits undertaken. 8. Appointed authorising engineer for fire safety in place through NHS shared services (specialist estates services). 	<ol style="list-style-type: none"> 1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Patient Committee.

Gaps in Controls/mitigations
<ol style="list-style-type: none"> 1. Insufficient revenue funding to maintain the active and passive fire safety measures within the infrastructure to ensure compliance . 2. Insufficient capital to upgrade active and passive fire safety measures within the infrastructure.

Progress since last submission

1. Controls in place reviewed and strengthened to provide clarity on the audit activity undertaken and by who to ensure the risk reflects the current position.
2. Gaps in controls have been reviewed and updated to align with the current risk position.
3. The Estates and Facilities Team are actively watching for the release of the new legislation with regards to the outcomes of the Grenfell enquiry to ensure BCUHB are sighted and pro-active on the potential changes in legislation and policy that will impact on the health sector.
4. Funding has been received from EFAB and statutory compliance monies to ensure the completion of the proposed works in a timely manner which is being progressed by the Estates and Facilities Team.
5. Action ID 12273 - Proposal to close the action as the findings have been actioned ahead of the anticipated completion date.

Links to

Strategic Priorities

Strengthen our wellbeing focus
Making effective and sustainable use of resources (key enabler)

Principal Risks

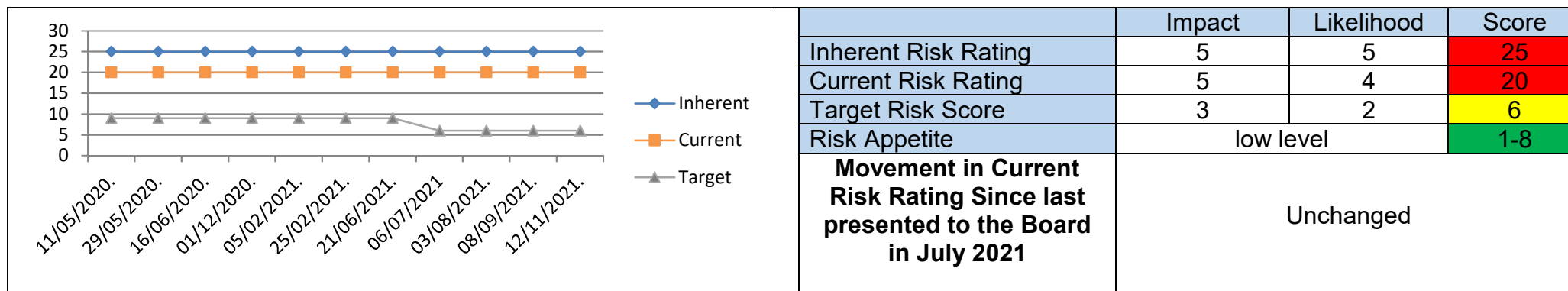
BAF21-13
BAF21-17

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	12273	Review Internal Audit Fire findings and ensure all actions are taken.	Mr Rod Taylor, Director of Estates and Facilities	31/12/2021	ACTION CLOSED - 05/11/2021 Governance actions completed and operational elements are captured within the gap analysis areas below. Action completed ahead of time, request approval of closure. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	Completed

	12274	Identify how actions identified in the site FRA are escalated to senior staff and effectively implemented.	Mr Rod Taylor, Director of Estates and Facilities	31/03/2022	Escalation through Hospital Management Teams, Area Teams and MH&LD management teams with site responsible persons has been completed. Assurance on implementation of actions outstanding. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12275	Identify how site specific fire information and training is conducted and recorded.	Mr Rod Taylor, Director of Estates and Facilities	30/06/2022	Database located within the fire safety files, managed and updated by the fire safety trainer. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021.	On Track
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates and Facilities	30/09/2022	Work in progress. To be included in site specific manual and training developed with Manual Handling team.	On Track
	12279	AlbaMat training - is required in all service areas a specific training package is required with Fire and Manual Handling Team involved.	Mr Rod Taylor, Director of Estates and Facilities	31/03/2022	Albac mat training is undertaken as part of the induction programme for clinical staff and as part of the refresher-training programme delivered by the Manual Handling team. Original action due date was 30/09/2022. Approved reduction at QSE 07/09/2021. Extension of the action due date	On Track

					from 30/11/2021 to the 31/03/2022 approved at QSE on the 02/11/2021.	
	15036	Fire Risk Assessments in place Pan BCUHB.	Mr Rod Taylor, Director of Estates and Facilities	30/09/2022	Improve safety and compliance with the Order.	On Track

CRR20-05	Director Lead: Director of Primary and Community Care	Date Opened: 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 12 November 2021
	Risk: Timely access to care homes	Date of Committee Review: 02 November 2021
		Target Risk Date: 30 June 2022
There is a risk that there will be a delay in residents accessing placements in care homes and other community closed care settings. This is caused by the need to protect these vulnerable communities from the transmission of the virus during the pandemic. This could lead to individual harm, debilitation and delay in hospital discharges impacting on quality of care, wider capacity and patient flow.		



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

<p>11. North Wales care home escalation and support tool that complements national work programmes has been implemented, monitored as part of the North Wales care homes single action plan at RPB.</p> <p>12. Communication with care homes at a local level and across North Wales as part of the North Wales care homes single action plan.</p> <p>13. MDT Care Home group meeting daily Monday to Friday, for issue resolution for period of enhanced second covid wave pressures.</p> <p>14. Re-establishment of the North Wales Silver Health and Social care group reporting into the Strategic Control group, to identify where joint responses are required and shared learning.</p> <p>15. Contribution to the incident management teams in outbreaks/incidents within care homes.</p> <p>16. Welsh Government have issued a SoP for the management of outbreaks. SoP has been implemented within the independent hospitals.</p>	
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Gaps in Controls/mitigations
<p>1. There is a massive shortage in accessing domiciliary care support, a scoping exercise has been completed, principals agreed and in the process of temporarily extending the bridging services as part of Community Resource Team's</p> <p>2. Changes in Government Strategy is affecting the Nursing Homes, Welsh Government guidance is still awaited.</p> <p>3. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for MFD patients, currently being collected manually.</p>

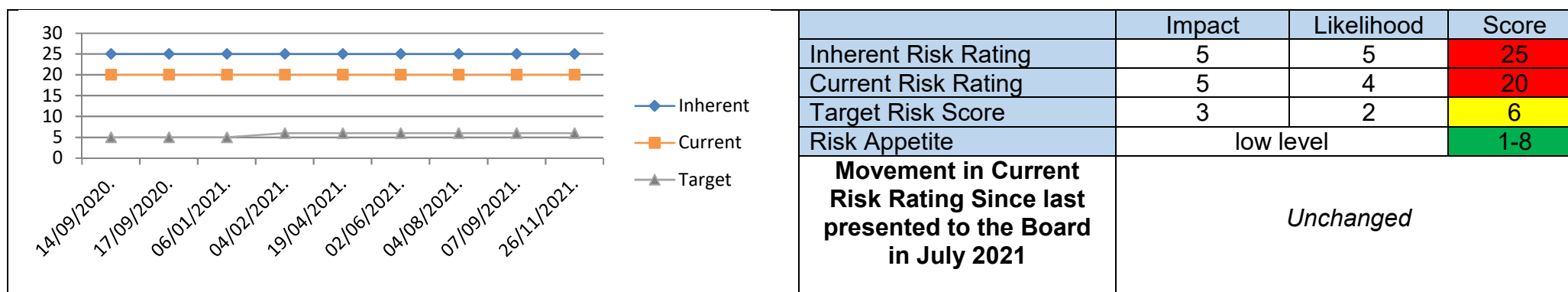
Progress since last submission
<p>1. Following approval at QSE Committee on the 02/11/2021, the target risk due date for the risk has been updated and extended to the 30/06/2022.</p> <p>2. All groups are continuing to meet to review as part of the QAF Process; i.e. data collection from Local Authorities, quality audit tools, communications and engagement with the sector.</p> <p>3. Reduction in the number of care homes under COVID restrictions, however increase in the number of care homes restricting admissions due to staffing and quality and safety issues.</p> <p>4. Draft QAF being presented for approval at the Senior Nursing Forum at the end of November 2021.</p> <p>5. Performance Assurance Report drafted looking at areas such as pressure ulcers in care homes, safeguarding, homes in escalating concerns etc. to be included in the overall Performance Assurance Report moving forward.</p> <p>6. Controls in place and gaps in controls reviewed and updated to align with current risk position.</p> <p>7. Action ID 18025 - Proposal to extend the action due date to the 30/4/2022 to allow sufficient time for the requirement for a review of the proposal by the regional board for mandate to progress.</p> <p>8. An additional action has been identified to develop an interim relief bank of health and social care staff which will provide a level of flexibility for staffing in the care homes and will support the reduction in the likelihood of the risk occurring.</p>

Links to Strategic Priorities		Principal Risks
Primary and community care		BAF21-03

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14949	Development of resources support capacity and demand for care homes.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	28/02/2022	<p>This will help eradicate delays in discharge through better co-ordination.</p> <p>Draft framework is in place and we have setup 6 different work streams to implement the various strands of the Quality Assurance Framework.</p> <p>Extension to the original action due date from 30/06/2021, approved at QSE 07/09/2021.</p>	On Track
	18024	To work with LAs to review domiciliary care resource across North Wales.	Ms Jane Trowman, Care Home Programme Lead	28/02/2022	It will improve patient flow by enabling patients to be discharged to their own homes.	On Track
	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/12/2021	<p>It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge.</p> <p>Request extension to the due date to 30/04/2022, to allow for approval at Regional Board.</p>	Delay

	18646	MFD - Work with local authorities and care provides to implement an agreed action plan	Ms Jane Trowman, Care Home Programme Lead	31/12/2021	Improved flow and discharge of patients in a more timely manner, and improve the quality of care to patients.	On Track
	20074	Development of an interim relief bank for health and social care	Mrs Marianne Walmsley, Lead Nurse Primary and Community	31/01/2022	Allow flexibility in relation to staffing within homes.	On Track

CRR20-08	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 26 November 2021
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Date of Committee Review: 02 November 2021
		Target Risk Date: 30 June 2022
There is a risk that patients may come to harm of permanent vision loss. This may be caused by reduced capacity resulting from Covid-19 and increase in waiting times for clinic review as clinics have been cancelled.		
This may negatively impact on patients through untreated proliferative diabetic retinopathy, untreated glaucoma, untreated age related macular degeneration, prolonged suffering and may result in falls from impaired vision due to lack of cataract secondary capacity due to prolonged surgical capacity reduction during the pandemic. This could negatively also impact on patient safety and experience, the quality of care, finance through claims, and the reputation of the Health Board.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Reviewing list of patients affected to get fast-track or book those who may deteriorate to clinics. 2. Cataract - All cataracts have been stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. Once surgery resumes across all sites patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access as part of the 'Once for North Wales' process. 4. More clinic slots are being made available to accommodate clinically pressing patients. 5. Diabetic retinopathy now in place across all 3 sites. 6. Cataracts - A new contract is in place to outsourcing to Spa Medica and mobilisation has begun with the opportunity for up to 400 cataracts and 70 YAG capsulotomy procedures per month. 	<ol style="list-style-type: none"> 1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative group. 3. Monthly reports to WG against KPI's for eye care measure and KQI's. 4. All Wales and MIAA audits have taken place, and reports received to which BCU is responding. In addition two clinical condition audits are undertaken annually by Welsh Government.

5. Performance reviewed at secondary care accountability meetings.
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Gaps in Controls/mitigations

1. They are continuing to stratify patients into R1, R2 and R3 to enable prioritisation of permanent sight lost. However, further table-top risk stratification is challenged by reduced OBD (Office Based Decision) making by clinicians as a consequence of their return to expanded clinical activities.
2. Surgery has recommenced but the Pan-BCU cataract PTL (to reduce inequality) has yet to be operationalised.
3. Diabetic retinopathy in place in two of the three Sites with West Site still to achieve flow to Primary Care.
4. Current partnership pathways which mitigate waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition, however, a significant number of patients do not have a clinical condition logged on the system.
5. Guidance for number of cataracts being undertaken per list is currently set to 6-8, the health board is running at 3.6-4, differences in national standards between number of cataract procedures per list.
6. Following approval of the internal eye care business case, recruitment to support additional Intra Vitreal Therapy capacity as well as the digital programme is ongoing.

Progress since last submission

1. Following approval at the QSE Committee on the 02/11/2021 the target risk due date has been extended from 28/02/2022 to the 30/06/2022.
2. Gaps and controls in place have been updated to reflect the current risk position.
3. An additional action has been identified for recruitment to support additional Intra Vitreal Therapy capacity as well as the digital programme.

Links to

Strategic Priorities

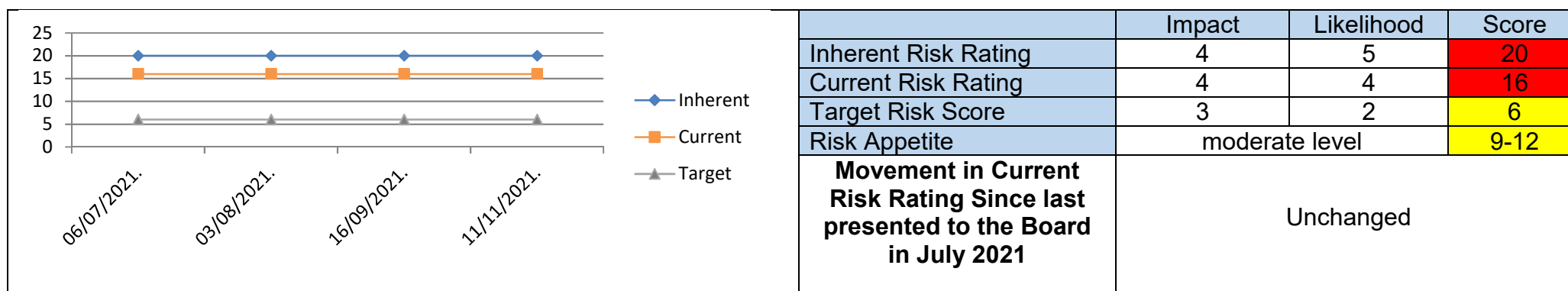
Recovering access to timely planned care pathways
Strengthen our wellbeing focus

Principal Risks

BAF21-02
BAF21-04

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	14908	The retinal cameras have been procured as part of a larger equipment replacement scheme and are expected to be commissioned soon. Date awaited from internal sources.	Mr Srinivas Singaram, Specialty Doctor	31/12/2021	This action will enable the service to effectively mitigate and manage this risk so as to achieve its target score.	On Track
	15662	Proliferative diabetic retinopathy – Pan BCUHB pathway has been initiated to get optometry review of the backlog. Referrals being sent out from secondary care to primary care optometrists and are at various stages of progression but positive progress.	Mr Srinivas Singaram, Specialty Doctor	31/12/2021	This action will enable the service to appropriately mitigate and manage this risk in attaining its target score.	On Track
	20392	Following approval of business case, recruitment of clinical and admin posts for Intra Vitreal Therapy capacity and technical posts for the digital project.	Alyson Constantine, Site Acute Care Director	31/12/2021	Additional Intra Vitreal Therapy capacity and more patients can be seen within target time. Technical posts will allow progression of digital implementation.	On Track

CRR21-13	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee Quality and Safety Group	Date Last Reviewed: 11 November 2021
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	Date of Committee Review: 02 November 2021
		Target Risk Date: 30 December 2022
There is a risk to the provision of high quality safe and effective nursing care due to the number of nursing vacancies across the Health Board. This may be caused by the increasing age profile within the nursing workforce, difficulties with recruitment and retention of nursing staff across the Health Board, geographical challenge and competition with other hospitals across the borders. There is also the precarious position of Bank & Agency staffing in terms of continuity of supply and the impact this has on skill mix and patient experience. This has been further exacerbated by the impact on the resilience of the workforce due to the ongoing Covid 19 pandemic.		
This could lead to negative impact on the safe delivery of highly quality, timely patient-centred care and enhanced experience, financial loss due to reduction in business/operational activities and potential reputational damage to the Health Board.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Safe Care supports the daily review of staffing in Acute and Community Areas across the Health Board to ensure safe deployment in line with existing Safe Staffing Act. 2. Double sign off of nursing rosters to ensure effective deployment. 3. Nurse staffing policy outlines standards and escalation. 4. Safe staffing legislation being extended into Paediatric inpatient areas from Q3 2021. 5. District Nursing principle compliance review undertaken bi annually in line with AW approach. 6. Biannual staffing Inpatient reviews - reviewing establishments and association of harms with reports to QSE/Board. 7. Workforce recruitment and retention strategy in place. 8. Recruitment and Retention operational group insitu with HB wide representation. 	<ol style="list-style-type: none"> 1. Risk is regularly reviewed and monitored at the Site Quality and Safety meeting. 2. Bi-annual nurse staffing review undertaken that is overseen by Quality, Safety and Experience Committee as the designated committee, as well as the approval of the Nurse Staffing policy. 3. Risk is regularly reviewed and monitored at the Senior Nursing Meeting.

<p>9. Targeted Recruitment Campaign for Band 5 nurses developed and rolled out.</p> <p>10. Annual Commissioning requirements calculated triangulating service development/staffing review and national planning information.</p> <p>11. International Nurse recruitment programme in place informed by data analysis.</p> <p>12. Clinical Fellows for Nursing programme being rolled out.</p> <p>13. ADN appointment to lead and support nurse recruitment.</p> <p>14. Workforce/Service planning process to triangulate requirements.</p> <p>15. Introduction of new roles to support e.g. Band 4 roles across the HB where applicable.</p> <p>16. Daily redeployment meeting with Senior Nursing Leadership chair during pandemic surge. Currently twice weekly.</p> <p>17. MDT staffing support across the Health Board during surge due to inability to respond to demand.</p> <p>18. Objective setting via the PADR process to ensure staff are working to 'top of license' and have opportunity.</p> <p>19. Pandemic surge plan approved by Executive Director of Nursing and Midwifery, the plan has been implemented within the Health Board.</p> <p>20. Workforce nursing utilisation dashboard developed and introduced to senior nursing teams to optimize nurse staffing rosters.</p> <p>21. Band 4 roles review completed with actions identified to progress identified roles through to fasttrack nursing studies resulting in band 5 positions going forwards.</p>	<p>4. Welsh Government oversight of nurse staffing as well as tri-annual summary submission.</p>
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Gaps in Controls/mitigations
<p>1. There remains some variability in adherence to the Rostering Policy in relation to application of rotas, approval and KPIs. e.g. Annual Leave.</p> <p>2. There are some instances of reliance on paper-based rotas rather than electronic rotas which lead to manual checking of staffing on a daily basis which is less efficient.</p> <p>3. Not all Nursing staff groups are on electronic rotas and not everyone is IT literate, due to personnel changes there is a requirement for refresher training.</p> <p>4. Whilst the recruitment and retention strategy and plan are in place, there are extenuating circumstances outside of the Health Board's control which could impact on the programme.</p>

Progress since last submission
<p>1. Positive development made in terms of recruitment in both permanent and temporary workforce, recognising that the support required to manage the current pandemic is impacting the ability to reduce the current risk level.</p> <p>2. Risk handler has been updated to reflect recent changes in roles.</p> <p>3. Staffing Act has been extended to include paediatrics inpatient areas since the 01/10/2021.</p> <p>4. Controls in place and gaps in controls reviewed to align with current risk position.</p>

5. Action ID 17509 - Proposal to extend the action due date to 30/11/2022 was not approved by ET and further clarification has been requested. The new CNO for Wales is keen for an All Wales approach – this is an element of the national recruitment and retention work stream that is being looked at and the timeframe for completion is therefore outside the control of the Health Board.
6. Action ID 17508 – Proposal to close the action as this has been completed.
7. An additional action has been identified to develop and implement a programme of work to ensure the impact of the safe staffing act is embedded in the Health Board's business planning cycle, which will support a more integrated approach to ensure the safe staffing act is met through pathway re-design and nurse re-deployment across the Health Board.

Links to	
Strategic Priorities	Principal Risks
Effective alignment of our people (key enabler) Strengthen our wellbeing focus	BAF21-02 BAF21-09 BAF21-11 BAF21-18

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Workforce Optimisation Advisor	30/11/2021	<p>This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume.</p> <p>The individual benefits and KPIs of the business case are linked to the relevant sections of our corporate risk register.</p> <p>Extension of the due date from 30/9/2021 to the 30/11/2021 approved at QSE 02/11/2021.</p>	On Track

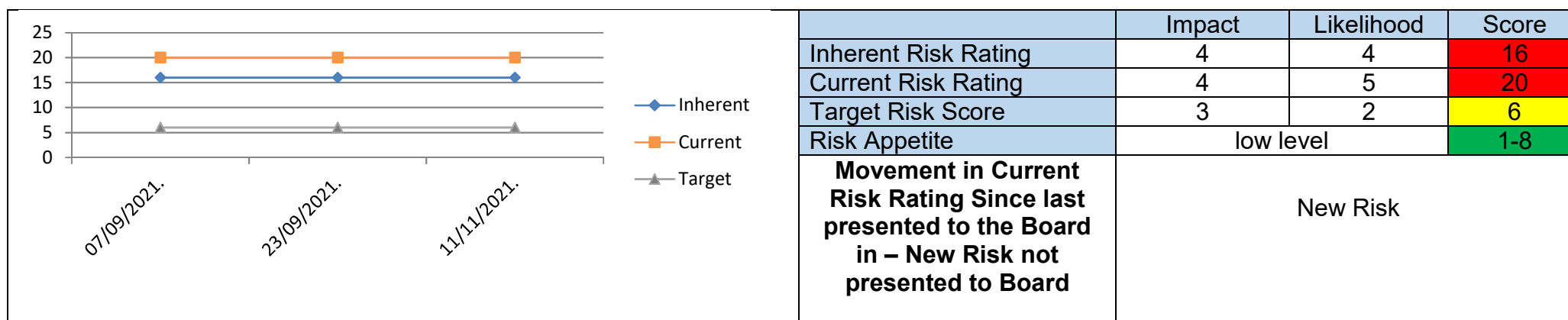
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce.	On Track
	17508	Development of collaborative Career Clinics supported by Workforce & Organisational Development.	Mrs Anne-Marie Rowlands, Associate Director Professional Regulation	31/08/2021	ACTION CLOSED - 31/08/2021 This action will continue to further develop career pathway opportunities and aid stability within the current workforce	Completed
	17509	Exploration of the Welsh equivalent Global Learning Programme.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	30/11/2021	The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development Request further extension to the action due date from 30/11/2021 to the 30/11/2022 to enable completion of the action, not approved at Executive Team 22/12/2021 until further clarification provided.	Delay
	18834	Introduce targeted monitoring across rosters, through KPI management to reduce agency expenditure and maximise substantive staff usage.	Mr Nick Graham, Workforce Optimisation Advisor	31/12/2021	Effective utilisation of substantive staff	On Track

	18835	Support and progress existing band 4 roles through to fastrack nurse training and support and progress band 2/3 nursing roles into future band 4 roles for succession planning.	Mrs Alison Griffiths, Associate Director of Nursing Workforce	30/12/2022	This action will enable the Health Board to be in a position to grow our own nursing workforce which will reduce overall vacancy rates and provide continued long term sustainable workforce.	On Track
	20039	Develop and implement a programme of work to ensure the impact of the safe staffing act is embedded in the Health Board's business planning cycle.	Mandy Jones, Assistant Director of Nursing	30/12/2022	By embedding into the business planning cycle this will support a more integrated approach to ensure the safe staffing act is met through pathway re-design and nurse re-deployment across the Health Board.	On Track

CRR21-14	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 20 August 2021
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 23 December 2021
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Date of Committee Review: 02 November 2021
		Target Risk Date: 31 October 2022

This may be caused by the new Case Law of Cheshire West, which widens the parameters of activity resulting in more patients requiring assessment for deprivation of liberty and the Supreme High Court Judgement in September 2019, which removed the consent of parents when detaining a young person [16/17 yr olds] for care and treatment within NHS settings.

This could lead to harm to patients from unlawful detention, increase in Court of Protection Activity (COP), which may result in greater operational pressures, and increase in financial cost, poor patient experience and reputational damage for BCUHB.



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Formal reporting and escalation of activity, mandatory compliance and exception reports are reported to the Mental Health Act Committee, Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory training is in place for MHLA and key departments and is included within the mandatory adult at risk level 2 and 3 training. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised DoLS Procedure [SOP] is in place and it provides a clear process and guidance to reduce legal challenge [21a]. 5. DoLS COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact. 	<ol style="list-style-type: none"> 1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis.

	5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews.
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Gaps in Controls/mitigations

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

Progress since last submission

1. Following approval at the QSE Committee on the 02/11/2021, the target risk due date for the risk has been updated and extended to the 31/10/2022.
2. Following previous discussions regarding the current risk score being higher than the inherent risk score, due to increased activity the current risk (likelihood) score has increased from the inherent risk of 16 to a 20 following a 44% increase in activity.
3. Development of terms of reference for a strategic implementation task group for Liberty Protection Safeguards, inaugural meeting to take place in November 2021.
4. Successful if WG bid for MCA training and DoLS backlog activity which will commence in December 2021.
5. Successful Welsh Government bid for Mental Capacity Act training and DoLS backlog activity which will commence in December 2021.
6. Controls in place and gaps in controls reviewed to align with current risk position.
7. Action ID 15704, 15706, 15707 – Proposal to close these actions as they have been completed following a request for clarification from ET on the 22/12/2021.

8. Action ID 15708 and 18118 – Proposal to extend the action due dates were not approved by ET, further clarification for the delay has been requested.

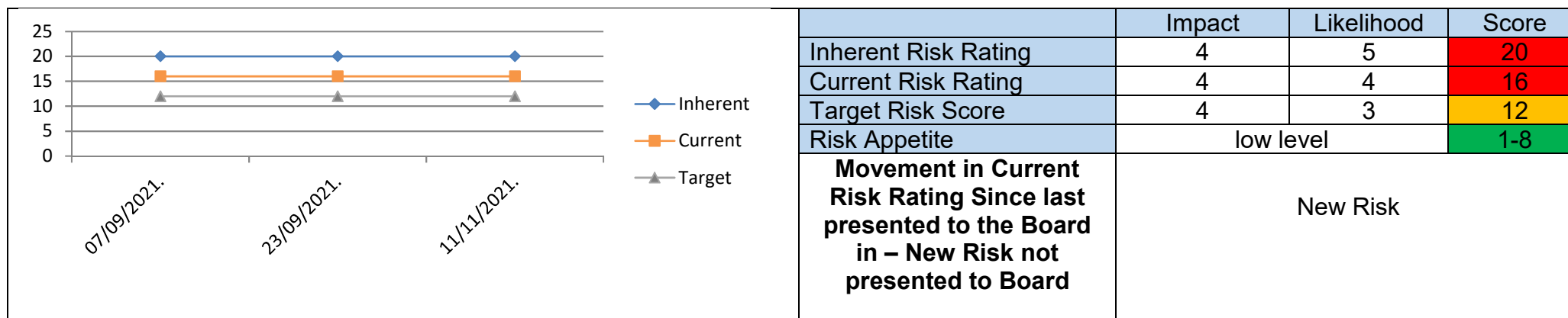
Links to	
Strategic Priorities	Principal Risks
Strengthen our wellbeing focus	BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15704	The Business Case to support the structure will be presented to the Executive Team.	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable implementation of the SSW[W] Act and will reduce risk.	Complete
	15705	The National Task and Finish Group Finish Group will support the implementation of the [LPS] legislation and Code of Practice ensuring National consistency for NHS organisations.	Miss Andrea Davies, Personal Assistant	31/12/2021	The National Task and Finish Group will develop indicators specific to the NHS which will reduce unlawful detention and risk. 11/11/2021 - Still awaiting receipt of national code of practice.	On Track
	15706	LPS Training and guidance documentation and review of the DoLS forms has been agreed to be reviewed and developed by a leading Barrister and is supported by an agreed memorandum of understanding.	Miss Andrea Davies, Personal Assistant	31/10/2021	An informed workforce will comply with revised legislation which will reduce unlawful detention and risk	Complete

	15707	Finance to be secured due to cost pressures for S12 Dr activity, external BIA assessments and CoP activity. (To be included within the Business Case)	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable the implementation of the SSW[W] Act and compliance with the MCA and the new Mental Capacity [Amendment] Act 2019 and will reduce risk.	Complete
	15708	The DoLS Governance arrangements and reporting structures of BIA's are to be reviewed to ensure improved reporting and escalation of non-compliance with legislation for the both the Managing Authority and Supervisory Body.	Miss Andrea Davies, Personal Assistant	31/10/2021	<p>The Memorandum of Understanding provides step by step guidance which will reduce error and improve quality and reduce unlawful detention.</p> <p>Request extension of the due date to the 31/11/2021 to allow for the embedding of the structure to take place was not approved at Executive Team 22/12/2021.</p>	Delay
	15709	The BCUHB LPS Implementation Task and Finish Group will be implemented and will support the transition of DoLS as guided by the new LPS legislation.	Miss Andrea Davies, Personal Assistant	31/12/2021	<p>Additional resource will enable the implementation of the SSW[W] Act and Mental Capacity [Amendment] Act 2019 and will reduce unlawful detention and risk.</p> <p>Requesting extension of due date to 31/12/2021 to complete action and implement task and finish group due to delay in publication of the code of practice.</p> <p>Extension to the due date approved at QSE on the 02/11/2021.</p>	On Track

	18117	Recruitment to new posts required due to implementation of LPS.	Michelle Denwood, Associate Director Safeguarding	01/04/2022	Additional resource will ensure the legal requirements of LPS will be implemented and will reduce the number of unlawful detentions.	On Track
	18118	Implement and Monitor a Court of Protection Engagement and Procedure SoP for DoLS / LPS.	Michelle Denwood, Associate Director Safeguarding	31/10/2021	<p>The pathway will reduce delay, improve communication and reinforce organisational accountability. This will improve activity with the COP and meet the needs and safeguards of service users.</p> <p>Request extension of the due date to the 31/12/2021 to finalise and ratify the documentation was not approved at Executive Team 22/12/2021.</p>	Delay
	18983	Implement changes in line with publication of new code of practice which will include revised job descriptions, training packages, audits, supervision, and strengthened court of protection activity.	Michelle Denwood, Associate Director Safeguarding	31/10/2022	Reduce the risk by improving education and implementation of legislation which will reduce unlawful detention.	On Track
	18984	Review of all policies, procedures and guidance in line with publication of the new code of practice.	Michelle Denwood, Associate Director Safeguarding	31/10/2022	BCU will be compliant with legislation and provide guidance to service users.	On Track

CRR21-15	Director Lead: Executive Director of Nursing and Midwifery	Date Opened: 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 23 December 2021
	Risk: There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Date of Committee Review: 02 November 2021
		Target Risk Date: 01 April 2022
There is a risk that the Health Board may not discharge its statutory and moral duties in respect of Safeguarding with regards to Safeguarding Adults /Children/Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] including the wider harm agenda and Deprivation of Liberty Safeguards [DoLS] while recognising the activities of the Managing Authority and Supervisory Body.		
This may be caused by a failure to engage and implement appropriate safeguarding arrangements, develop an engaged and educated workforce and provide sufficient resource to manage the demand and complexity of the portfolio.		
This could lead to harm to persons at risk of harm to which BCUHB has an duty of care, potential financial claims, poor patient experience and reputational damage to the Health Board.		



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

4. The Children's Division BCUHB are managing the recruitment process for the replacement of the named Doctor. Interim arrangements are in place and all statutory safeguarding meetings are attended by a Doctor.	safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / Children's Board to scrutinise safeguarding mortality reviews.
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Gaps in Controls/mitigations	
1. The increase in safeguarding activity, with enhanced complexity has resulted in the prioritisation of aspects of service delivery. This is supported by the data reporting activity and the identification of risk. This has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. 2. Inability of safeguarding specialists to be in attendance at required meetings. Standardised Reporting Tools are in place to ensure reporting and consistent activity and data collection is communicated. 3. The lack of comprehensive digital clinical patient records reduces the identification of risk, results in the delay of information and communication and is time consuming. Safeguarding mandatory fields are in place within Symphony and other departments which have limited digital patient records. 4. Lack of consistent approach by the 6 local authorities in north wales to implement guidance as a result of national policies and procedures. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB, is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. 5. Named Doctor Safeguarding Children - this post remains vacant. The additional two sessions for the Named Doctor have supported the recruitment process, the post remains vacant and the statutory meetings are supported by community paediatricians and overseen by Corporate Safeguarding Team Members, however the level of multi-agency and local clinical engagement is limited. 6. Funding in place, capacity within current resources remains challenged.	

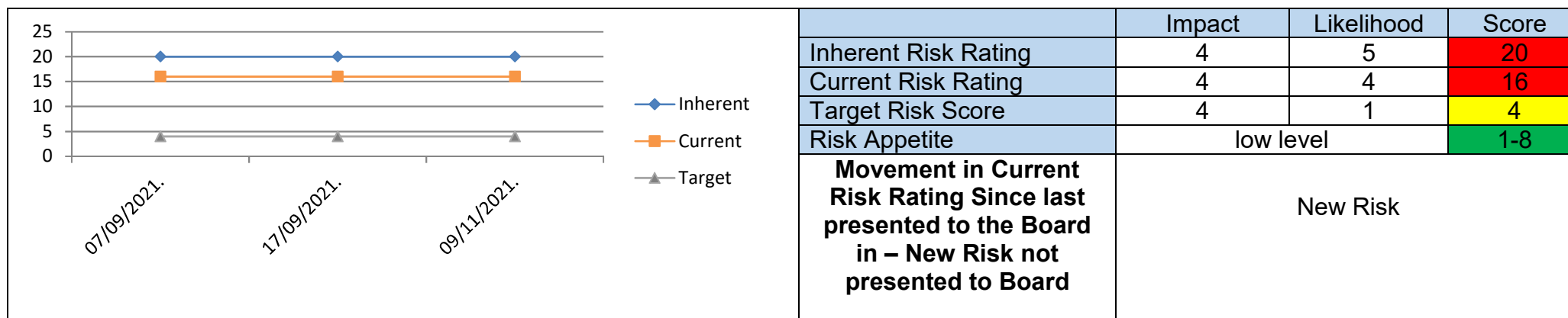
Progress since last submission	
1. Controls in place and gaps in controls reviewed and updated to align with current risk position. 2. QSE Committee on the 02/11/2021 noted that the Executive Team recognise and have agreed to the target risk score remaining outside of the Health Boards risk appetite given the multi-faceted arena the safeguarding agenda is. 3. Action ID 15701, 15702 and 18115 – Proposal to close these actions as they have been completed following a request for clarification from ET 22/12/2021 regarding the business case being approved. 4. Action ID 18113 - BCU workforce are currently undertaking the establishment of task groups which include the safeguarding team. 5. Action ID 18120 – Additional national task group set up by WG to include mental health homicide review, BCU reps from safeguarding and Mental health have been put forward and agreed to be included on the task group. 6. Successfully identified 2x independent advocate posts for health across two regions, with a period of review and funded by WG.	

Links to Strategic Priorities		Principal Risks
Strengthen our wellbeing focus		BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15701	The agreement and consultation of the Safeguarding Business Case is to take place by the Executive Director of Nursing. Which will be followed by further Consultation with the Executive Management Team.	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable implementation of the SSW[W] Act and will reduce risk.	Complete
	15702	The inclusion of an identified domestic abuse [VAWDASV] post to be agreed as part of the Business Case	Miss Andrea Davies, Personal Assistant	31/10/2021	Additional resource will enable implementation of the VAWDASV priorities and statutory regulation and will reduce risk.	Complete
	18113	Implementation and Monitoring of Workforce Safeguarding Responsibilities SoP [SSWWACT 2014].	Michelle Denwood, Associate Director Safeguarding	20/12/2021	The process and the development of KPI's can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings.	On Track
	18115	Advertisement and Recruitment of the Named Dr Safeguarding Children/Children at Risk.	Michelle Denwood, Associate Director Safeguarding	20/12/2021	Ensure full compliance with legislation and ensure clinical strategic and operational safeguarding responsibilities are met.	Complete

	18116	To Implement and Monitor strengthened governance and reporting pathways for SARC.	Michelle Denwood, Associate Director Safeguarding	10/01/2022	Compliance with legislation and early identification of risk and harm.	On Track
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Associate Director Safeguarding	01/04/2022	The revised procedures will support the identification of risk and mitigation which is supported by an IT platform [repository]. This will collate the findings of the reviews to identify trends and support the reduction of Organisational risks.	On Track

CRR21-16	Director Lead: Executive Director of Workforce and Organisational Development	Date Opened: 22 April 2021
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 09 November 2021
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Date of Committee Review: 02 November 2021
		Target Risk Date: 20 June 2023
There is a risk that insufficient Manual Handling training could lead to staff and patient injury, lost work time, HSE enforcement action (current related Improvement Notice for Patient Falls) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, particularly in the West region, reduction in class sizes due to COVID-19 restrictions and insufficient numbers of trained staff. This could lead to an impact on compliance as set at an All Wales level and requires BCUHB to have a compliance of 85% for Patient handling refresher and 100% prior to new starters / students undertaking patient handling duties.		



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Recruitment programme has been approved and is in place as part of the H&S business case 2. A blended approach has been put in place for inanimate load handling, to increase training compliance for those that do not require the practical element of module B of the passport. 3. Recommended face to face training to improve compliance took place in July 2021 and will continue where appropriate and safe to do so. 4. ESR bookings for courses for staff to self-book onto sessions, right up to the day of courses is now available. 5. Risk assessments and SOP in place for training rooms. 6. Additional rooms secured and funding agreed to allow the additional training to take place. 	<ol style="list-style-type: none"> 1. Regular oversight and review by the Occupational H&S team. 2. Reviewed at the Strategic Occupational Health and Safety Group and agreement to escalate at the SOHS Group. 3. Risk Management Group oversight. 4. Local Partnership Forum.

Gaps in Controls/mitigations

1. Although the training programme is in place there is currently a national shortage of manual handling trainers. Re-advertisement for posts is continuing.
2. Full roll out of the module A training will require a programme of testing of knowledge and awareness throughout the course.
3. Training has been re-established in the West, on a short term basis until January 2022 on the Bryn Y Neuadd site when it is anticipated that the additional rooms will become available.
4. The All Wales Passport sets minimum standards for training, with module B of inanimate load requiring practical training. The current blended approach does not allow for module B practical to be covered, but does cover all other elements required for module A & B from the Passport.
5. Numbers reduced due to social distancing requires increased classes to be offered and ensure the numbers of staff requiring training can attend. This is difficult to achieve without training rooms and additional trainers.
6. ESR systems not easy to use. Staff often ring trainers or email for help to book onto courses. ESR contact emails not always up to date, unable to contact attendees booked of changes to session booked or cancelled courses.
7. Review the rate of DNA's and evaluation of causes of none attendance remains gap in the system. This will be undertaken by the new band 6 roles, when in post.
8. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the MH Passport Scheme. The business case has been agreed for two years but this remains a gap in the controls until recruitment has been agreed. Current compliance for Patient Handling refresher is now at 55%.
9. Improved reduction in original capacity within the team to deliver the training requirement, 1 x staff member on long term absence. Continuing with recruitment programme to recruit Trainer/Advisor rolls from external for an additional 6 members of staff.

Progress since last submission

1. Controls in place and gaps in controls reviewed and updated to align with the current position of the risk, including the reduction in compliance with training. Whilst 1 secondment post trainer is in place, recruiting to the further temporary posts is proving problematic for the team. Work continues to progress this matter.
2. An additional training room has been achieved to increase training capacity.
3. Training 5 days a week is now in place.
4. Risk assessments in place for new starters to ensure limitations to roles are clear until manual handling training has been completed.
5. Theory training for students is being delivered via teams to large groups to reduce pre-organised training (approximately 450 students put through this process).
6. Risk Handler updated to reflect current change in roles.
7. Action ID 17978, 17979 and 18859 – Proposal to extend the action due dates were not approved by ET on the 22/12/2021, further clarification requested to support the timeframe extension, which will be included in the next iteration of the risk.

Links to Strategic Priorities		Principal Risks
Strengthen our wellbeing focus		BAF21-13

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17978	Renting of temporary training rooms in West, Central & East. SBAR has been approved for 2 year leases on the premises, awaiting contracts to be finalised.	Clare Jones, Interim Corporate Health And Safety Manager (manual Handling Lead)	30/11/2021	Having additional rooms to provide manual handling training for staff will reduce risk mitigation by allowing an increasing the number of courses that can be delivered, increase the number of staff trained and increase compliance for BCUHB. Request extension to due date to 31/12/2021 due to time to sign and agree contracts was not approved at Executive Team 22/12/2021. Further clarification requested.	Delay
	17979	Additional trainers sought, to be clinically trained as per the standards set within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Clare Jones, Interim Corporate Health And Safety Manager (manual Handling Lead)	30/11/2021	Additional trainers to provide training to the standard set within the Passport for clinical qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB. Request extension to due date to 31/03/2022 to allow sufficient time to recruit to posts not approved at Executive Team	Delay

					22/12/2021. Further clarification requested.	
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Clare Jones, Interim Corporate Health And Safety Manager (manual Handling Lead)	31/12/2021	Target areas to ensure those with higher need for people handling training have been offered and can attend as priority. This should reduce the risk of injuries to both staff and patients if those who handle patients more-often have the appropriate training.	On Track
	18859	Finalise approve and implement MH policy and plan.	Clare Jones, Interim Corporate Health And Safety Manager (manual Handling Lead)	31/12/2021	Gives staff an understanding of their obligation to undertake and access manual handling training which reduces the likelihood of injury to both patients and staff. Request extension to due date to 31/03/2022 due to workload and capacity within the team to deliver was not approved at Executive Team 22/12/2021. Further clarification was requested.	Delay
	18860	ESR to be reviewed to include manual handling 1A and 1B training courses for inanimate load level 1.	Clare Jones, Interim Corporate Health And Safety Manager (manual Handling Lead)	31/03/2022	Support the risk and allow correct compliance and correct level of training, reducing the risk of injury for those attending class for a competency assessment.	On Track

CRR21-17	Director Lead: Director of Primary and Community Care	Date Opened: 26 July 2021
	Assuring Committee: Quality, Safety and Experience Committee	Date Last Reviewed: 03 November 2021
	Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Date of Committee Review: 02 November 2021
		Target Risk Date: 31 October 2022

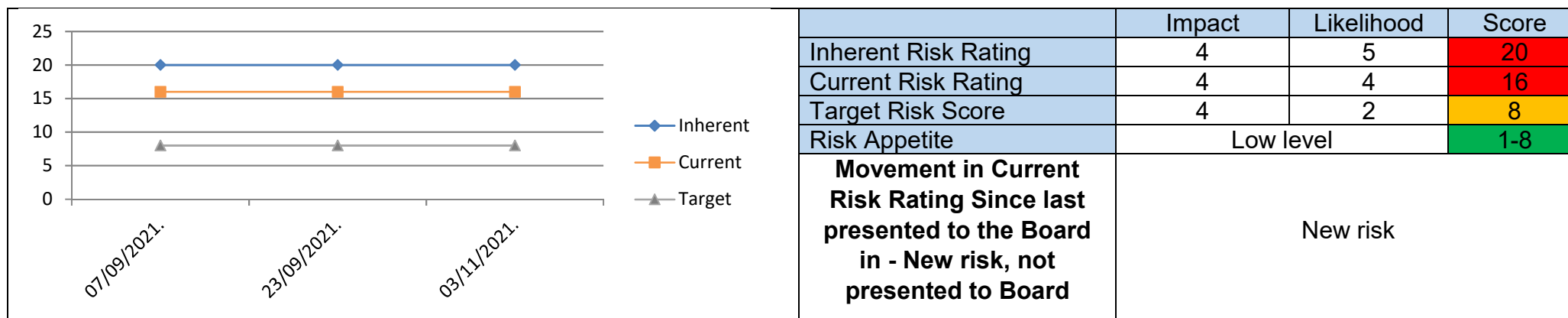
There is a risk that Young people attending Emergency Departments, Paediatric wards in crisis and out of hours with suicidal behaviour/ideation, actual self-harm and those detained out of hours under a s136 may not always receive timely access to CAMHS to ensure highest quality patient-centred care.

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

- Current operational hours of CAMHS is 9am-5pm over 7days a week.
- CAMHS psychiatrists are limited in how they can respond out of hours to complete a S136 assessment. There is often a requirement for social care involvement to facilitate a safe discharge from the section, which is not available out of hours.
- increase in demand which may be linked to the restrictions of lockdown and Covid-19 pandemic.
- crisis presentations to A&E with associated social care placement breakdowns leading to young people remaining on acute paediatric wards for prolonged periods waiting for suitable placement by Local Authority.
- awaiting a CAMHS Tier 4 bed following a mental health assessment.

The environments within the Emergency Departments and S136 suites are not designed to meet the needs of young people experiencing a psycho-social or mental health crisis. Whilst the paediatric wards may be considered, age appropriate they are also not designed to meet this type of need within their environments.

This may negatively impact on patient experience, quality of patient care, on longer detention in s136., delay in discharge and the reputation of the Health Board. This could also lead to distress, behaviour challenges and possible risk to other young people and staff, and delay in treatment to other young people who may need to access Paediatric wards.



Controls in place	Assurances
<ol style="list-style-type: none"> 1. Local individual risk assessment undertaken by nursing staff as part of the Paediatric admission process. 2. CAMHS practitioners provide 7 day service and support to the paediatric wards for a limited number of hours (i.e. 9-5pm, 7 days a week). 3. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 4. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5 pm for young people up to their 18th birthday and out of hours telephone on-call rota. 5. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 6. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 7. Safeguarding discharge SOP for young people in place. 8. Daily SITREP reporting between Paediatrics and CAMHS. 9. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements. 	<ol style="list-style-type: none"> 1. A scoping exercise or SBAR of CAMHS Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCU approach. 3. Risk also regularly discussed at the Area - Quality and safety group. 4. Risk, controls and actions in place have been sufficiently shared with key stakeholders, i.e. the Local Authority and Police. 5. Pre Jet Meeting with WG, joint with MH division on a quarterly basis.

Gaps in Controls/mitigations
<ol style="list-style-type: none"> 1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff, which has been exacerbated by the lockdown arising from Covid-19. Currently working with recruitment agency and established multi-disciplinary team is already in place. 2. Lack of suitable LA placements or shared safe environments within which young people can be assessed or discharged to. 3. Lack of agreed criteria, threshold and standardisation for reporting related incidents.

Progress since last submission
<ol style="list-style-type: none"> 1. Following approval at the QSE Committee on the 2nd November 2021, the target risk due date has been extended from the original date of 31st March 2022 to the 31st October 2022. 2. An additional action ID19594 has been recorded to develop a programme of auditing completed risk assessments as part of the admissions pathways on a quarterly basis. 3. An additional action ID19595 has been developed which will allow for further analysis of the incidents reported in order to determine what further actions may be required to support appropriate and consistent reporting of incidents across the wards / services. This will support the gap in controls identified. 4. Conversations ongoing with Welsh Government to pilot the use of safe spaces within BCUHB and will help to support the gap in controls identified. 5. Delivery Unit is undertaking a review of Mental Health Crisis Care during November 2021, with the report anticipated in January 2022.

6. Controls, assurances and risk scoring reviewed with no proposed further changes to ensure they remain up to date with the current risk position.
7. Action ID 17961 – Proposed extension of due date to the 17/12/2021 to allow time for confirmation from each area that this action has been undertaken was not approved at ET on the 22/12/2021. Progress has been provided to confirm 2 out of the 3 regions have submitted their assessments and further chasing will continue with the remaining central region.

Links to Strategic Priorities		Principal Risks
Improved USC pathways Integration and improvement of MH Services		BAF21-01 BAF21-08

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways	On Track
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing CAMHS.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to meet the needs of young people before crisis occur as most of their needs are psycho-social and not just MH.	On Track
	17961	Targeted ligature assessments to be undertaken on Paediatric wards to identify ligature points to support existing preventative measures already in place.	Mr Martin McSpadden, Head of Nursing, Children's Acute and Community Services	29/10/2021	Ensure a safe environment by identifying all ligature points on the ward. Request extension of due date to the 17/12/2021 to allow time for confirmation from each area that this action has been	Delay

					undertaken was not approved at Executive Team 22/12/2021. Further clarification from the lead has confirmed 2 out of the 3 areas have submitted their risk assessments.	
	17962	To recruit additional staff/agency to support individual young people as required.	Marilyn Wells, Head of Nursing	31/03/2022	It will support timely access to support and treatment in relation to the demand that has been experienced. The increase in workforce will enable us to provide more out-of-hour response.	On Track
	17963	Task and Finish Group to review SCH03 policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	30/12/2021	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions.	On Track
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ A&E staff, Local Authority and North Wales Police.	Marilyn Wells, Head of Nursing	31/03/2022	Create awareness and develop skill in assessment and improve staff morale.	On Track
	18334	Identification and development of suitable shared (non hospital) environment for comprehensive assessment of needs and development of a plan to address needs across agencies.	Marilyn Wells, Head of Nursing	31/10/2022	Provision of an age appropriate environment that provides an appropriate alternative to hospital.	On Track
	19594	Develop a programme of auditing risk assessments as part of the admissions pathways on a quarterly basis.	Mr Martin McSpadden, Head of Nursing, Children's Acute and	01/02/2022	The risk assessment and audit process will provide a greater level of assurance and support the reduction in the risk score, whilst recognising that the paediatric wards cannot be a	On Track

			Community Services		completely ligature free environment.	
	19595	Further analysis of the incidents reported in order to determine what further actions are required to ensure appropriate reporting of the incidents.	Ms Janw Hughes-Evans, Head of Nursing Children's Services	31/01/2022	Provides a greater understanding of the incidents occurring and the measures required to be put in place to support both staff and patients and supports a safer environment.	On Track

Appendix 2 - Full list of all Corporate Risk Register including current risk scoring

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control	Executive Director of Finance	QSE	15
CRR20-02	Contractor Management and Control	Executive Director of Finance	QSE	15
CRR20-03	Legionella Management and Control	Executive Director of Planning and Performance	QSE	16
CRR20-04	Non-Compliance of Fire Safety Systems	Executive Director of Planning and Performance	QSE	16
CRR20-05	Timely access to care homes	Executive Director of Primary and Community Care	QSE	20
CRR20-06	Informatics - Patient Records pan BCU	Executive Director of Primary and Community Care	PPPH	16
CRR20-07	Informatics infrastructure capacity, resource and demand	Executive Director of Primary and Community Care	PPPH	16
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients	Executive Director of Nursing and Midwifery	QSE	20
CRR20-09	Potential harm to patients arising from delays in patient IVT Treatment - Not approved for escalation by QSE Committee, risk being managed at Tier 2			
CRR20-10	GP Out of Hours IT System - De-escalated by DIG Committee, risk being managed at Tier 2			
CRR21-11	Cyber Security	Executive Director of Primary and Community Care	PPPH	20
CRR21-12	National Infrastructure and Products	Executive Director of Primary and Community Care	PPPH	20
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	Executive Director of Nursing and Midwifery	QSE	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients	Executive Director of Nursing and Midwifery	QSE	20

CRR21-15	There is a risk that patient and service users may be harmed due to non-compliance with the SSW (Wales) Act 2014	Executive Director of Nursing and Midwifery	QSE	16
CRR21-16	Non-compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	Executive Director of Workforce and Organisational Development	QSE	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours	Executive Director of Primary and Community Care	QSE	16

Risk Key Field Guidance / Definitions of Assurance Levels

BAF / Risk Template Item	Please refer to the Risk Management Strategy and Policy for further detailed explanations	
Risk Reference	Definition	Reference number, allocated by the Board Secretary for the Board Assurance Framework (BAF) or the Corporate Risk Team for the Corporate Risk Register (CRR)
Risk Description	Definition	A summary of what may happen that could have an impact on the achievement of the Health Board's Priorities or an adverse high level effect on the operational activities of the Health Board. There are 3 main components to include when articulating the risk description (event, cause and effect):
		- There is a risk of / if
		- This may be caused by
		- Which could lead to an impact / effect on
Risk Ratings	Inherent	Without taking into consideration any controls that may be in place to manage this risk, what is the likelihood that this risk will happen, and if it did, what would be the consequence.
	Current	Having considered the key controls and key mitigation measures in place, indicate what the current risk grading is. Note – this should reduce as action is taken to address the risk.
	Target	This is the level of risk one would expect to reach once all controls and key mitigation measures are in place and actions have been completed. This would normally align to the risk appetite, however when new controls / mitigations will take longer than 12 months to achieve, an interim target may be used (see Target Risk Date).
Risk Impact	Definition	The consequence (or how bad it would be) if the risk were to happen; in line with the National Patient Safety Agency (NPSA) Grading Matrix, an impact of 1 is Negligible (very low), and 5 is Catastrophic (very high).
Risk Likelihood	Definition	The chance that the risk will happen. In line with the NPSA Grading Matrix a likelihood of 1 means it will never happen / recur, and a 5 means that it will undoubtedly happen or recur, possibly frequently.
Risk Score	Definition	Impact x Likelihood of the risk happening, using the 5 x 5 Risk Scoring Matrix.
Target Risk Date	Definition	This is the date by which the target score will be achieved. It may indicate a stepping stone to achieve the risk appetite. Where the target risk score is outside the risk appetite, this field should also include the date by which the risk appetite will be achieved.
Risk Appetite	Definition	The amount and level of risk that the Health Board is willing to tolerate or accept in order to achieve its priorities. This could vary depending on the type of risk. The Board will review the risk appetite on a regular basis, and have implemented a Risk Appetite Framework to allow for exceptional circumstances.
	Low	Cautious with a preference for safe delivery options.

Risk Key Field Guidance / Definitions of Assurance Levels

	Moderate	Prepared to take on, pursue, or retain some risks for the Health Board to maximise opportunities to improve quality and safety of services.
	High	Open or willing to take on, pursue, or retain risks associated with innovation, research, and development, consistent with the Health Board's Priorities.
Controls	Definition	These are measures/interventions implemented by the Health Board to reduce either the likelihood of a risk and/or the potential magnitude/severity of its impact were it to happen. A collection of strategies, policies, procedures and systems - to control the risks that would otherwise arise, and ensure care and services are delivered by competent staff who are aware of how to raise concerns [NHS WALES Governance e-manual - http://www.wales.nhs.uk/governance-emanual/risk-management]. A measure that maintains and/or modifies risk (ISO 31000:2018(en)).
	Examples include, but are not limited to	<ul style="list-style-type: none"> - People, for example, a person who may have a specific role in delivery of an objective - Strategy, policies, procedures, SOP, checklists in place and being implemented which ensure the delivery of an objective - Training in place, monitored, and reported for assurance - Compliance audits - Business Continuity Plans in place, up to date, tested, and effectively monitored - Contracts in place, up to date, managed and regularly and routinely monitored
Mitigation	Definition	This refers to the process of reducing risk exposure and minimising its likelihood, and/or reducing the severity of impact were it to happen. Types of risk mitigations include the 5Ts (treat, tolerate, terminate, transfer, or take opportunity).
	Examples include, but are not limited to	<ul style="list-style-type: none"> - A redesigned and implemented service or redesigned and implemented pathway - Business Case agreed and implemented - Using a different product or service - Insurance procured.
Assurance Levels	1	The first level of assurance comes from the department that performs the day to day activity, for example the compliance data that is available
	2	The second level of assurance comes from other functions in the Health Board who have internally verified that data, for example quality, finance, and human resources assurance.
	3	The third level of assurance comes from outside the Health Board, for example the Welsh Government, Health Inspectorate Wales, Health and Safety Executive, and Internal/External Audit, etc.

Cyfarfod a dyddiad: Meeting and date:	11.01.2022 Pwyllgor Ansawdd, Diogelwch a Phrofiad						
Cyhoeddus neu Breifat: Public or Private:	Cyhoeddus						
Teitl yr Adroddiad Report Title:	Adroddiad Ansawdd a Phefformiad hyd at 30.11.2021						
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill Cyfarwyddwr Gweithredol Cyllid						
Awdur yr Adroddiad Report Author:	Mr Edward Williams Pennaeth Sicrwydd Perfformiad						
Craffu blaenorol: Prior Scrutiny:	Mae'r data a'r gwybodaeth yn yr adroddiad hwn wedi bod yn destyn gwaith craffu gan y Prif Swyddog Gweithredol						
Atodiadau Appendices:	Dim						
Argymhelliad / Recommendation:							
Gofynnir i'r Pwyllgor Ansawdd, Diogelwch a Phrofiad graffu ar yr adroddiad ac ystyried a oes angen ystyried uwchgyfeirio unrhyw faes ir Bwrdd Iechyd.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	<input checked="" type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input checked="" type="checkbox"/>	Er gwybodaeth For Information	<input checked="" type="checkbox"/>
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:							
Mae'r adroddiad yma yn cynnwys mesuriadau o Fframwaith Cyflawni GIG Cymru 2021-22. Mae'r Crynodeb Gweithredol wedi ei gynnwys yn yr Adroddiad.							
Cefndir / Background:							
Mae ein hadroddiad yn amlinellu'r materion perfformiad ac ansawdd allweddol sy'n flaenoriaethau o fewn dyletswydd dirpwyedig Pwyllgor Ansawdd, Diogelwch a Phrofiad. Mae crynodeb o'r adroddiad wedi'i gynnwys yn awr yn nhudalennau Crynodeb Gweithredol yr Adroddiad Ansawdd a Phefformiad ac mae'n dangos y gwaith sy'n gysylltiedig â'r mesurau allweddol sydd wedi'u cynnwys yn Fframwaith Cyflawni Cenedlaethol 2021-22. Mae'r fframwaith hwn wedi'i ddiwygio i ddarparu mesurau perfformiad o dan y Nodau Pedwarplyg a nodir yn Cymru Iachach.							
Asesu a Dadansoddi / Assessment & Analysis							
Goblygiadau Strategol / Strategy Implications							
Mae'r mesurau perfformiad yn yr adroddiad wedi'u halinio â'r Fframwaith Cyflawni GIG Cymru 2021-22.							
Opsiynau a ystyriwyd / Options considered							
Nid yw'n Berthnasol							

Not Applicable

Goblygiadau Ariannol / Financial Implications

Bydd cyflawni'r dangosyddion perfformiad yn ein cynllun blynyddol yn cael effaith uniongyrchol ac anuniongyrchol ar gynllun adferiad ariannol y Bwrdd.

Dadansoddiad Risk / Risk Analysis

Mae'r pandemig wedi creu nifer o risgiau i ddarparu gofal ar draws y system gofal iechyd.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Bydd yr adroddiad hwn ar gael i'r cyhoedd ar ôl ei gyhoeddi i'r Pwyllgor Ansawdd, Diogelwch a Pffrofiad.

Asesiad Effaith / Impact Assessment

Nid yw'r adroddiad hwn wedi bod yn destun Asesiad o'r Effaith ar Gydraddoldeb.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 11.01.2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Quality and Performance Report to 30 th November 2021						
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Hill Executive Director of Finance						
Awdur yr Adroddiad Report Author:	Mr Ed Williams, Head of Performance Assurance						
Craffu blaenorol: Prior Scrutiny:	The data and information in this report has been scrutinised by the Interim Director of Performance						
Atodiadau Appendices:	Quality and Performance Report						
Argymhelliad / Recommendation:							
Members of the Quality, Safety and Experience Committee are requested to scrutinise the report and advise any areas to be escalated for consideration by the Board.							
Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion	<input checked="" type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input checked="" type="checkbox"/>	Er gwybodaeth For Information	<input checked="" type="checkbox"/>
Sefyllfa / Situation:							
Delivery Measures 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



GIG
CYMRU
NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Quality and Performance Report

Quality, Safety & Experience Committee

Performance to 30th November 2021

Presented on 11th January 2022

Put patients first • Work together • Value and respect each other • Learn and innovate • Communicate openly and honestly

Title	Page	Title	Page
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About this Report	3	Quadruple Aim 4: Mortality and Timely Interventions	24 to 29
Summary Dashboard	4	Additional Information	30
Executive Summary	5	Quadruple Aim 2: Charts - : Children's & Young Adults Mental Health Services (CAMHS)	31
Quadruple Aim 1: Improved population health and Wellbeing	6 & 7	Quadruple Aim 2: Charts – Adult Mental Health	32 & 33
Quadruple Aim 2: Better Quality and more accessible healthcare	8	Quadruple Aim 3: Charts – Sepsis Six Bundles	34
Quadruple Aim 2: Infection Prevention & Control	9 to 11	Charts – Impact of COVID-19 on Activity	35 to 38
Quadruple Aim 2: Children's & Young Adults Mental Health Services (CAMHS)	12 to 14	Further Information	39

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

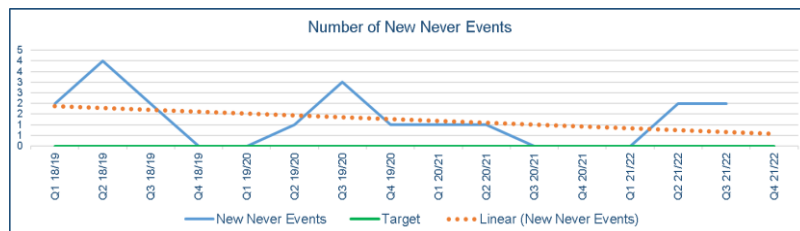
Ongoing development of the Report

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.

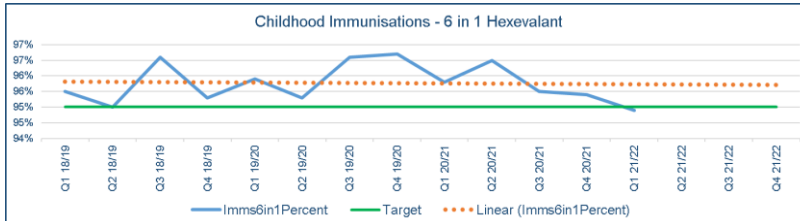
Summary Dashboard

Number of New Never Events*: **2**

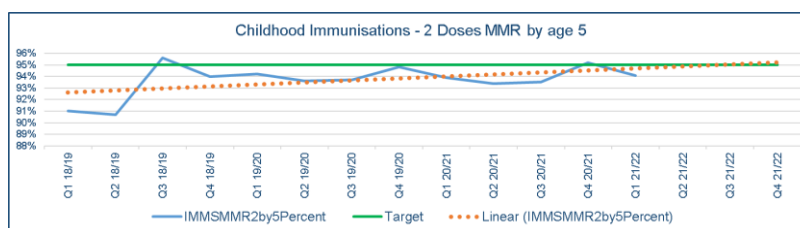


* Part Q3 between 1st October 2021 and 30th November 2021

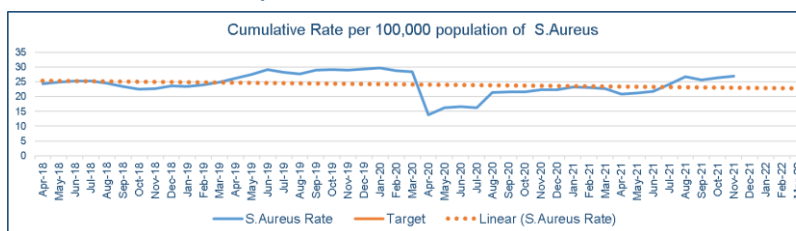
Immunisation - 6 in 1 Hexavalent: Q1 201/22 **94.9%**



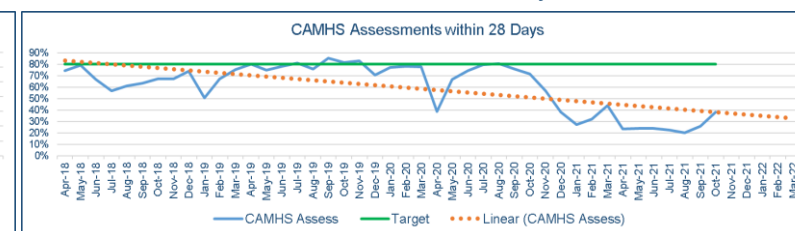
Immunisation- 2 doses MMR by 5: Q1 21/22 **94.1%**



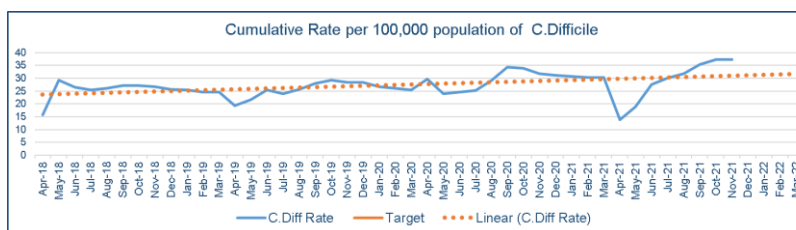
Cumulative Rate per 100,000 S.Aureus: **27.10**



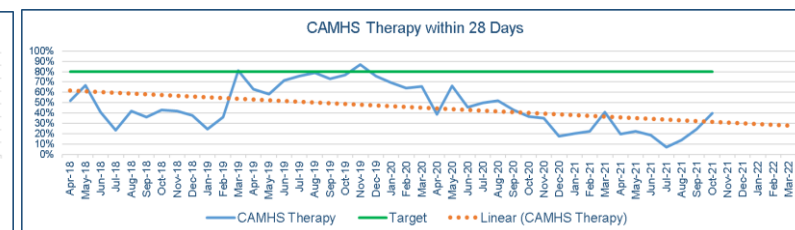
CAMHS – Assessed within 28 Days: **38.18%



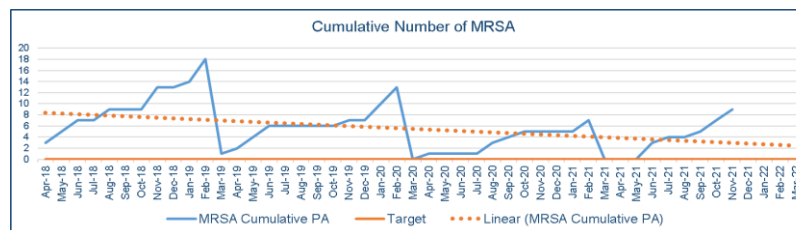
Cumulative Rate per 100,000 C.Difficile: **37.22**



CAMHS – Therapy within 28 Days: **40.0%

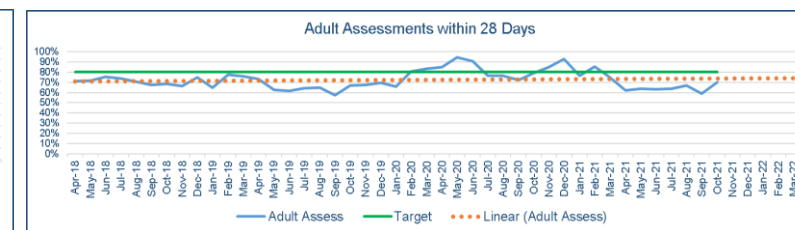


Cumulative Number of MRSA: **9**

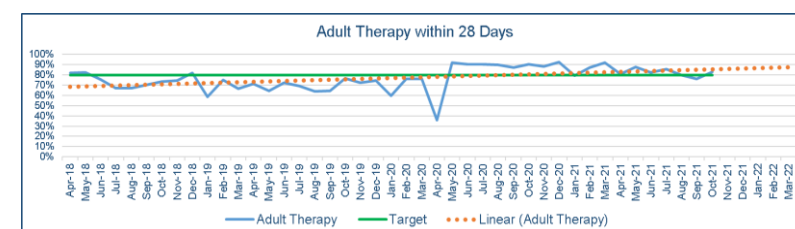


Cumulative rate resets on the 1st of April each year

Adult MH Assessed within 28 Days: **70.16%



Adult MH Therapy within 28 Days: **83.16%



**Mental Health Measures reported 1 month in arrears

The Committee are asked to note the following:

Quadruple Aim 1: Prevention

Despite the impact of the COVID-19 pandemic on most planned care services, it is encouraging to see that our immunisation of children programmes have continued to deliver throughout Quarter 2, 2021/22 at 94.9% of eligible children receiving 6 in 1 Hexavalent and 94.1% of eligible children receiving 2 doses of MMR vaccinations by age 5.

Quadruple Aim 2: Flu Vaccination

The 2021-22 flu vaccination campaign started in October 2021. The campaign continues alongside the increased focus upon the COVID-19 booster vaccination campaign. Despite the immense pressure upon our resources, both campaigns are delivering to expected trajectories.

Quadruple Aim 2: Infection Prevention

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

The infection prevention and control teams

continue to work on reducing the number of infections alongside their work on COVID-19.

Quadruple Aim 2: Mental Health

For Children's & Young Adults Mental Health Services (CAMHS) performance remains poor against the targets for the rate of children assessed within 28 days of referral. However, this month's position at 38.18%, and for those starting therapy within 28 days of assessment at 40% there has been a significant improvement compared to the previous report of 26.80% and 18.50% respectively.

Although improved, Performance against the 26 Week target or children awaiting neurodevelopment assessment remains poor at 31.90%, compared to 32.79% reported previously. It is expected that plans recently approved will enable us to increase capacity to see 120 children per month and this will translate to a much improved performance through Quarter 4.

For adult mental health services performance has improved as predicted, compared to the previous report, with percentage adults assessed within 28 days of referral at 70.61% compared to 63% reported previously. The number of patients starting therapy within 28 days of assessment remains above the 80% target at 83.16%.

There has been a consistent and significant improvement in the percentage rate of adults waiting less than 26 weeks to start psychological therapy and at 91% continues to consistently exceed the 80% target rate.

The number of patients experiencing delayed transfer of care (DToC) within our mental health has decreased from 16 reported in July 2021, to 11 in November 2021. The number of bed days lost to delayed transfers have also decreased to 625. whilst the service continues working to resolve issues that lead to DToC and it is expected that the number and length of DToC's will fall over the coming months, there will always be an element of delays to discharge due to the nature and complexities of the service.

Quadruple Aim 3: Quality & Safety

Two new Never Events were reported in the period from 1st of October 2021 to 30th November 2021. Both concerned retained objects.

The percentage closure rate of complaints managed under PTR < 30 working days (target 75%) has fallen from 64% reported in July 2021 to 48% to the end of November 2021. This remains an improvement compared to previous years, however, a combination of an increase in the number of complaints, and lack of capacity in services

(due to operational pressures) to investigate is impacting upon performance.

Quadruple Aim 4: Mortality and Timely Interventions

Crude Mortality (under 75 years old) has decreased to 0.94%. The mortality rate for BCU is lower than the Wales average of 1.13%. As BCU has not been an outlier for mortality for at least 24 months, it is suggested that there is no longer a need to provide an exception report on this.

Concern remains with regards the recording and monitoring of provision of Sepsis Six bundles both for our Inpatients and within our Emergency Departments. The Office of the Medical Director is currently reviewing this. Reporting of Emergency Department data and reporting recommenced in July 2021, however form completion remains significantly lower than levels prior to the COVID-19 pandemic.

Performance management

The Quality & Performance Report is currently being redesigned a model of the new Integrated Quality & Performance Report will be presented to the Health Board in January 2022. Thereafter, the new report will be rolled out to all of the Health Board's scrutinising committees from April 2022.

Quadruple Aim 1: People in Wales have improved health and well-being and better prevention and self management



People will take more responsibility, not only for their own health and well-being but also for their family and for the people they care for, perhaps even for their friends and neighbours. There will be a whole system approach to health and social care, in which services are only one element of supporting people to have better health and well-being throughout their whole 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.

Quadruple Aim 1: Measures

Period	Measure	Target	Actual	Trend
Q1 2021/22	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1*	>= 95%	94.90%	↓
Q1 2021/22	Percentage of children who received 2 doses of the MMR vaccine by age 5*	>= 95%	94.10%	↑
Q1 2021/22	Percentage of adult smokers who make a quit attempt via smoking cessation services**	>= 5%	1.20%	↓
Q2 2021/22	European Standardised rate of alcohol attributed hospital admissions for individuals resident in Wales	Reduce	357.6	↑
Q2 2021/22	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	Improve	74.20%	↑
2020/21	Percentage of babies who are exclusively breastfed at 10 days old	Improve	36.10%	↑
Oct 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged under 18 years)***	>= 90%	97.10%	↑
Oct 21	Percentage of health board residents in receipt of secondary mental health services who have a valid Care and Treatment Plan (aged 18 years & over)***	>= 90%	87.20%	↓

Period	Measure	Target	Actual	Trend
Nov 21	Cumulative uptake of the influenza vaccination among 65 and Over this season	75%	74.70%	N/A
Nov 21	Cumulative uptake of the influenza vaccination among Under 65 this season	55%	42.20%	N/A
2021/22	Uptake of the influenza vaccination among Pregnancy*	75%	****	N/A
Nov 21	Cumulative uptake of the influenza vaccination among Staff this season	60%	56.62%	N/A
Q1 2021/22	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	Improve	92.60%	↑

* 12 Month Trend

** Performance compared to same quarter previous year

*** Reported 1 month in arrears

**** Reported after the end of the Flu season - April 2022

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



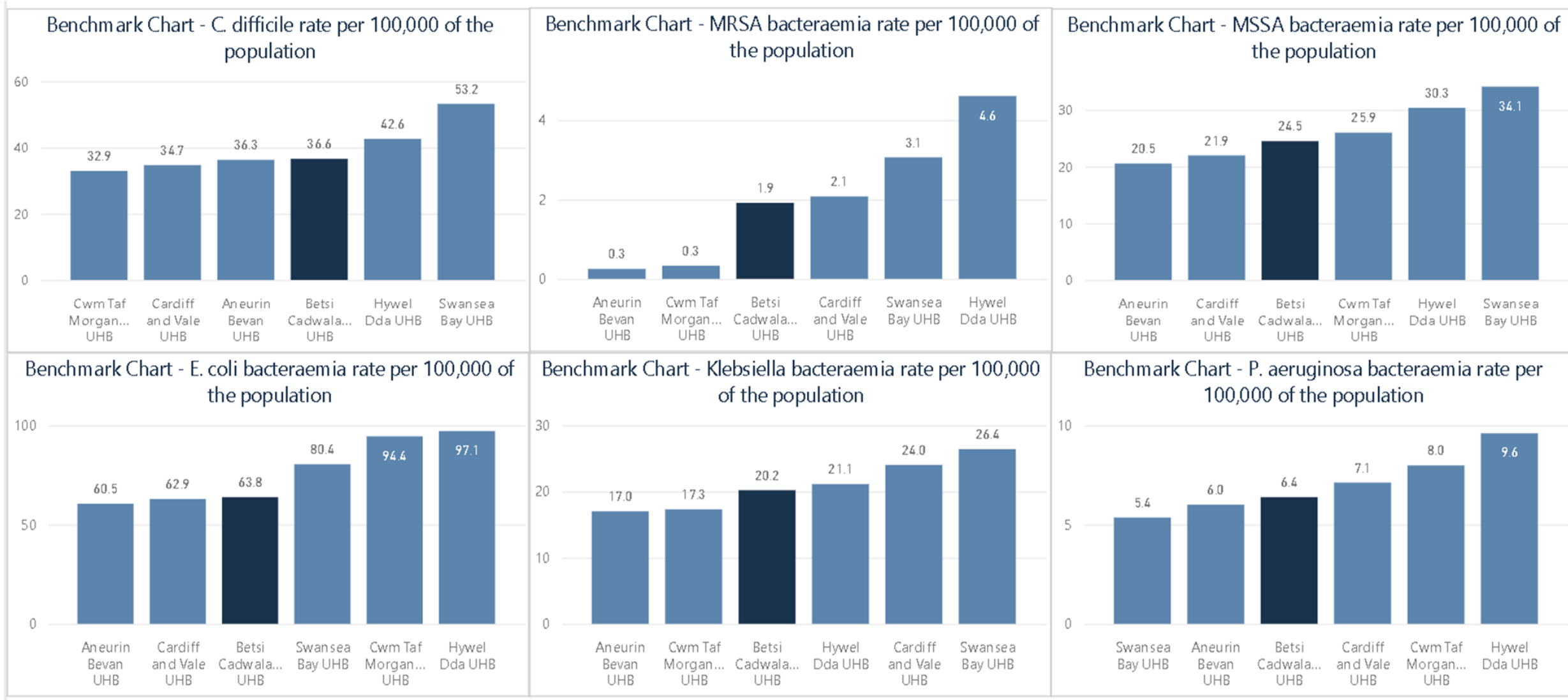
There will be an equitable system, which achieves equal health outcomes for everyone in Wales. It will improve the physical and mental well-being of all throughout their lives, from birth to a dignified end. Services will be seamless and delivered as close to home as possible. Hospital services will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

Quadruple Aim 2: Infection Control Measures

Period	Measure	Target	Actual
Nov 21	Cumulative rate of laboratory confirmed E-Coli cases per 100,000 population	<= 67	63.80
Nov 21	Cumulative number of laboratory confirmed E-Coli cases	N/A	300
Nov 21	Cumulative rate of laboratory confirmed S.Aureus cases per 100,000 population	<= 20	27.01
Nov 21	Cumulative number of laboratory confirmed S.Aureus cases	N/A	30
Nov 21	Cumulative number of laboratory confirmed C.Difficile cases	N/A	175

Period	Measure	Target	Actual
Nov 21	Cumulative rate of laboratory confirmed C.Difficile cases per 100,000 population	N/A	37.22
Nov 21	Cumulative number of laboratory confirmed MRSA cases	0	9
Nov 21	Cumulative number of laboratory confirmed MSSA cases	<= 40	118
Nov 21	Cumulative number of laboratory confirmed Klebsiela cases	<= 38	95
Nov 21	Cumulative number of laboratory confirmed Aeruginsoa cases	<= 10	30

Comparison Charts to all Health Boards in Wales – Apr to Nov 2021



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

Quadruple Aim 2: Infection Prevention

Issues Affecting Performance

Inappropriate use of Antibiotics and high levels of resistant organisms; BCU C. diff rate is 36.6 cases per 100K (down from 37.1 last month) but goal is 25.

Insufficient single rooms with appropriate ensuite facilities to meet requirements for patient isolation; needed both for patients with infections and those who are vulnerable.

COVID-19:

- COVID-19 infection rates remained high particularly in the West and there were outbreaks in YG and YGC. All swiftly managed to minimise numbers involved and there were no patient deaths related to the outbreaks. It was difficult to identify a source for the outbreaks; possibly due to asymptomatic visitors in at least one case.
- National guidance on Infection Prevention was updated in November.
- Significant number of staff have been isolating, particularly in the West, due to being household contacts of people with COVID-19.

Lack of inpatient decant facilities to enable high level cleaning with Hydrogen Peroxide Vapour (HPV), which is being further impacted by pressures in patient flow.

Infection Prevention Team: Significant vacancies and sickness in the Infection Prevention Nursing Team.

Actions and Outcomes

Antimicrobial improvement plan in progress. Also World Antibiotic Awareness week held in November with activities in GP practices, community pharmacies and hospitals. Compliance with Start Smart the Focus (SSTF) Ward Antimicrobial Prescribing Audits presented at Infection Prevention Steering Group.

Infection Prevention have provided clinical staff with a Single Room Risk Assessment to highlight priorities for siderooms and support decision making.

COVID-19:

- Inpatient testing regimes have been enhanced to help identify asymptomatic carriers early; all patients continue to be tested on admission but those who are negative are retested on day 2 and then twice weekly.
- The Safe Clean Care pilot to introduce lateral flow testing for visitors (alongside screening) has been successful and is to be rolled out across BCU in December.
- The new national guidance has been reviewed by the Infection Prevention team and key changes highlighted to clinical staff.
- The BCU policy regarding staff who are household contacts is being reviewed in light of changes to national and Welsh guidance.

Acute sites have been asked to review and update their HPV cleaning programmes.

Successful appointment of a new Director of Infection Prevention and Decontamination in November.

Risks and Mitigations




COVID-19: A risk assessment is being drawn up to look at allowing staff who are household contacts to return to work if certain strict criteria are fulfilled.

An alternative product to HPV is being piloted that is significantly safer and less time consuming than HPV, yet appears to be as effective.

A risk assessment relating to staff vacancies in the Infection Prevention Team to be drawn up. Meanwhile, work is being prioritised, clinical teams informed and vacancies are being recruited to looking at national and international.

The two Infection Prevention risks on the Board Assurance Framework (one on COVID and one on hospital acquired infection) have been reviewed and remain in place, scoring 15 and 16 respectively.

Quadruple Aim 2: Children & Adolescent Mental Health Services

Frequency	Measure	Target	Actual	Trend
Nov 21	Percentage of children and young people waiting less than 26 weeks for neurodevelopment assessment	>= 80%	31.90%	
Oct 21	Percentage of mental health (CAMHS) assessments undertaken within 28 days of referral*	>= 80%	38.18%	
Oct 21	Percentage of therapeutic interventions (CAMHS) within 28 days of assessment*	>= 80%	40.00%	

* Reported 1 month in arrears

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

What are the key issues/ drivers for why performance is where it is?

- Increased Demand - there has been an increase by 5% in total referrals since April 21, compared to 2019/20 pre-pandemic levels.
- Deterioration in core capacity for routine assessments and therapy available is multifaceted, in part related to pandemic social distancing requirements and changes in practice associated with the pandemic. Some capacity has been diverted to provide greater crisis capacity noting the increased crisis demand nationally.
- Complexity of referrals has also increased and affected new to review ratios by 30% when compared to 2019/20.

What actions are being taken to improve performance?

- A full tender exercise has been completed for additional external capacity, recommendations from tender was approved by Performance, finance & Information Governance (PFIG) Committee in December 2021 prior to approval at Board and then by WG prior to award. It is anticipated the contract will be available during Q4 this will support the ongoing improvement.
- A regional CAMHS performance group has been established under Targeted Intervention (TI) arrangements to address performance against the trajectory and to ensure that each team is delivering on expected outputs and recovery planning implemented at an early stage where applicable.
- Local capacity planning is being improved with supplemented training being provided to new colleagues in senior roles. A Training Programme for all staff groups is under development in conjunction with HEIW.
- A Performance Management Framework is being developed and with increased clarity of KPIs, responsibilities and accountability.
- Use of the Choice and Partnership Approach (CAPA) framework continues to be a priority, with the arrangement of further CAPA workshops across all Teams.
- Call for innovation with partners to utilise slippage on investment received into the service with a focus on prevention, early intervention and access.

When performance is going to improve by and by how much?

- Improvement seen ahead of forecast trajectories during October and November 2021. Additional capacity continues through an agreed external provider to support improved position. Based on current capacity from external provider it is anticipated that improvement in line with target of 80% of patients having waited under 28 days will be seen by end of Q1 2022/23. This is based upon trajectories that assume that the demand continues at expected levels, which will be continually reviewed.

What are the risks to this timeline?

- Should current vacancies and additional posts not be recruited this will impact on the core capacity within teams against planned trajectories
- Should demand for services, acuity and complexity of cases increase further this will impact on throughput of cases reducing core capacity for initiation of assessment and therapy
- Reduced uptake of private provider capacity

What are the mitigations in place for those risks?

Development of a workforce plan and recruitment strategy in progress with support from a recruitment agency

Performance management framework under development with escalation through TI Access Work Stream and CAMHS Strategic Improvement and Development Group

Weekly capacity and demand meetings in place and held across each team to monitor and manage flow.

Quadruple Aim 2: Neurodevelopment Service

What are the key issues/ drivers for why performance is where it is?

- Our core capacity to start new routine assessments is affected by a variety of factors related to the pandemic such as social distancing requirements, staff availability from isolating and changes in practice using IT.
- We have also identified a backlog of assessments that were started during the pandemic and remain incomplete. Plans are in place to address and monitor this work
- Core capacity continues to require the development and implementation of a service workforce improvement and development plan which has been commenced

What actions are being taken to improve performance and by who?

- A Regional ND Performance and Improvement Group will be established from January 2022, to ensure the development and monitoring of a service improvement plan.
- A Performance Management Framework for ND is being developed and will be implemented with increased clarity of KPIs, responsibilities and accountability. It is based on a similar model within CAMHS TI Service and will be adapted for the ND service
- Recruitment is underway for additional management support – in the form of a project manager regionally for ND Services, who will support and co-ordinate the Performance and Improvement Group and its subgroups
- Work is underway in each service with regards to the pandemic backlogs identified. Performance against this will be monitored.
- External Provider capacity has been increased from December through to end March 2022 to assist us with assessing the longest waiters this will be extended until June 2022, providing a further 500 assessments
- A full tender exercise will be undertaken for additional external capacity from July 2022 onwards, to enable us to sustain improvement while also undertaking work to understand what a sustainable service would look like

When performance is going to improve by and by how much?

- On the current performance and use of the external provider during 2021-22, the % waiting under 26weeks is predicted to improve from 23% in April 2021 to 42% in March 2022. This is an improved position towards the 80% WG target. Currently the target achievement in Nov 2021 is 36%






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
- Performance and Improvement Group does not convene in January 2021 – this will delay improvement plans
- Failure to appoint a Project Manager to support the service improvements/developments
- Failure to scope out the requirements of the new tender in a timely manner

What are the mitigations in place for those risks?

- Plans to recruit agency/bank staff to upload the external supplier referrals, weekly area monitoring of referrals.
- Explore using agency/bank staff initially to commence the project manager post and improvement planning
- Work commenced with teams to develop an agreed service approach using Vanguard methodology - 4 of 6 workshop sessions completed so far
- Regular escalation to Children Services Group, Area Leadership Teams and Children's Community Clinical Advisory Group

Quadruple Aim 2: Adult Mental Health Measures

Frequency	Measure	Target	Actual	Trend
Oct 21	Percentage of mental health (Adult) assessments undertaken within 28 days of referral*	$\geq 80\%$	70.61%	
Oct 21	Percentage of therapeutic interventions (Adult) within 28 days of assessment*	$\geq 80\%$	83.16%	
Oct 21	Percentage of patients (Adult) waiting less than 26 weeks to start a psychological therapy	$\geq 80\%$	91.0%	
Nov 21	Total Number of mental health delayed transfer of care (DToC) patients	Reduction	11	
Nov 21	Total Number of mental health delayed transfer of care (DToC) bed days	Reduction	625	

* 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?

- Since February 2021 the MH&LD DToC performance has improved significantly
- The reasons for delays are commissioning gaps which are being progressed.

What actions are being taken to improve performance and by who?

- Policy and process reviewed to ensure accuracy and consistency across BCUHB Mental Health & Learning Disabilities (MH&LD) Division.
- Divisional scrutiny panel weekly data considered, barriers identified and support and guidance offered by panel members.
- Delayed Transfer of Care Review Report presented to MH&LD, (SLT) weekly with escalations if required.

When performance is going to improve by and by how much?

- Weekly scrutiny and escalation to SLT in place
- Current DToC figures for November 2021 is 10 patients and 686 days (a reduction from 3000 bed days per month prior to February (2021)
- Action Plan developed aligned to recommendations of the DTOC review, updates provided monthly at Operational Leadership meeting and assurance report presented monthly at DSLT.
- Commissioning gaps being considered in future plans and division participating in All Wales Stranded Patients work programme.

What are the risks to this timeline and mitigations in place for those risks?

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

Quadruple Aim 2: Adult Psychological Therapy

Secondary Care Adult Mental Health Specialist Psychological Therapy: % patients seen referral to treatment in 26 weeks

Issues Affecting Performance

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

Key Issues/Drivers

- Implementation of Matrics Cymru 2017/2021 and the National Plan 2018.
- Capacity/Demand mismatch and challenges to stepped care approach increased W/Lists

Actions

- Successful Welsh Government (WG) funding bids from 2016 onwards supported recruitment of small increase in Adult Mental Health (AMH) secondary care psychology specialist resource which we targeted at waiting times/demand hotspots.
- AMH Psychology took over management of list in hotspot Wrexham
- Sustained Multidisciplinary Team (MDT) stepped care pathway work over last 3 years supported by the set up of the new AMH Psychology Stepped Care Initiative has increased psychological therapies provision from the MDT workforce across multiple services. Facilitated through a rolling supervision & training programme and increased direct provision of evidence based psychological therapy group interventions across Primary Care Mental Health (PCMH) and Community Mental Health Teams (CMHT) pan BCUHB.
- During COVID-19 this initiative developed and increased availability of digital resources and adaptations, making these accessible to mental health MDT clinicians pan BCUHB MH&LD services to support increased access and delivery of Cognitive Behavioural Therapy (CBT), Dialect Behavioural Therapy (DBT), and Coping Skills via group and individual input.
- Two rounds of external support have been organised to address the Wrexham legacy waiting list, now cleared.

Improvements

- Outcome is AMH secondary care specialist Psychological Therapies (PTs) compliance has steadily and consistently improved over the last 3 years from very low rates of compliance in Wrexham to now near compliance or full compliance across the region in the last 6 months.
- The West has dipped slightly this month. The overall workforce numbers are low, and we have had 1 retirement and 1 person leave their post In South Gwynedd affecting West's compliance.

Risks and Mitigation




- We are actively trying to recruit, and are using staff from elsewhere to manage clinical risks.
- Long-term sustainability supported by increased psychological therapies competences and skills in the wider MDT workforce across services as per the stepped care model (Matrics Cymru) via the AMH Psychology Stepped Care Initiative.
- Recruitment/retention plans for psychology staff resource in Stepped Care including PCMH, CMHTs, Inpatient Services, Perinatal, & Early Intervention Psychosis (EIP) Services. Recruitment of EIP and TSW Consultant Psychologists successful.

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



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

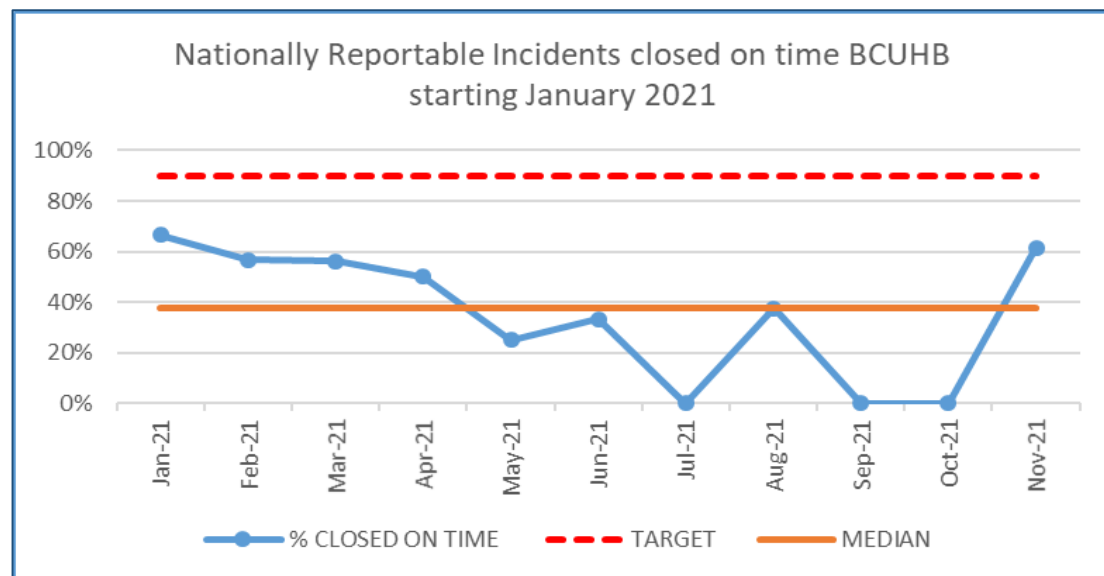
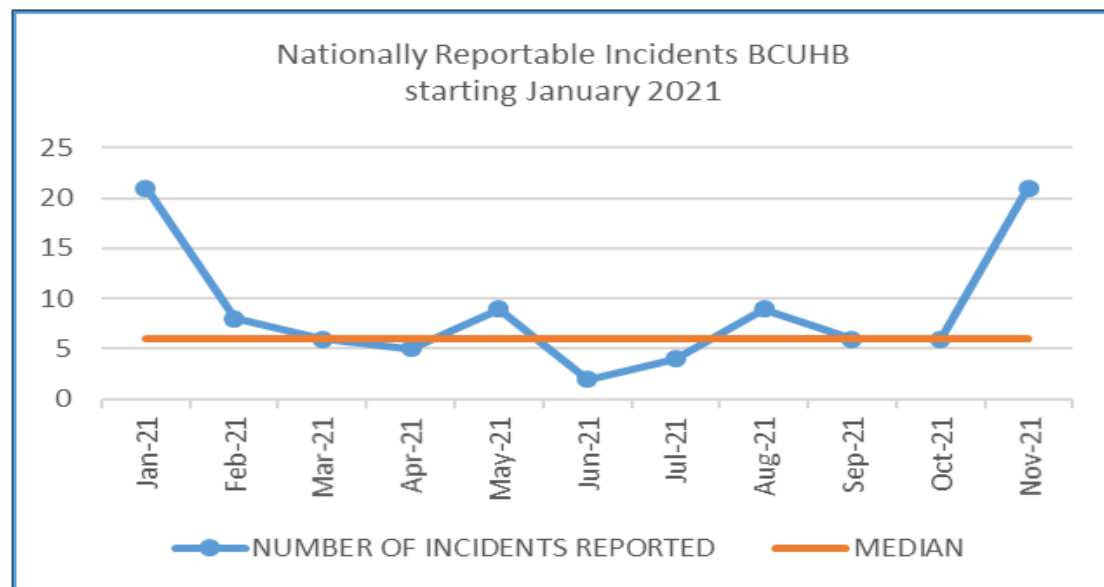
Quadruple Aim 3: Measures

Period	Measure	Target	Actual	Trend
'Nov 21	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%	48.00%	
Q3* 21/22	Number New Never Events**	0	2	
Oct 21	Doctor Appraisal / revalidation rate*	95%	80.69%	

* Number of New Never events Reported since 1st October 2021 to 16th December 2021.

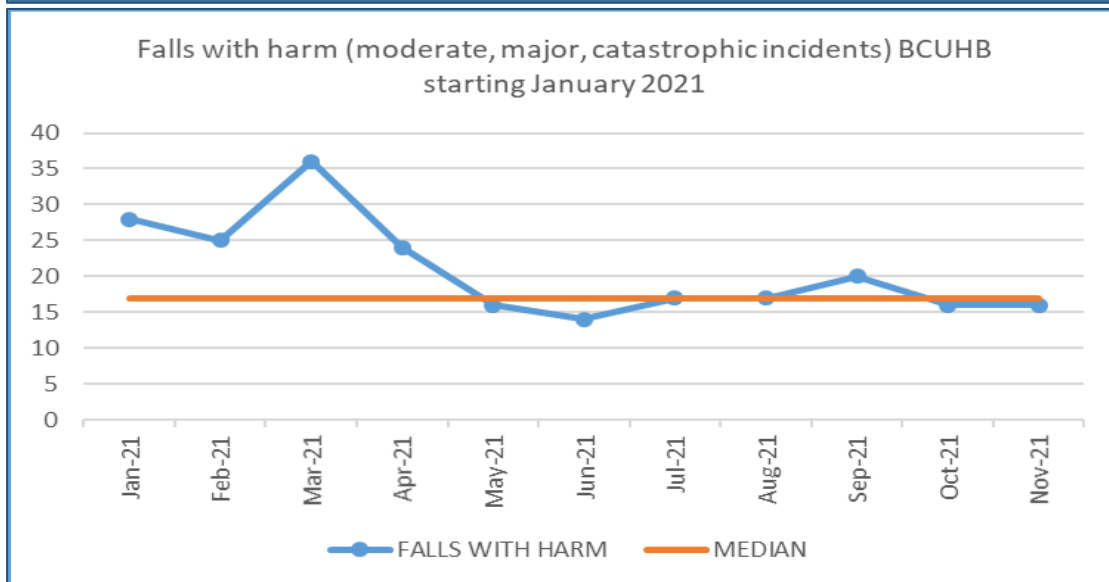
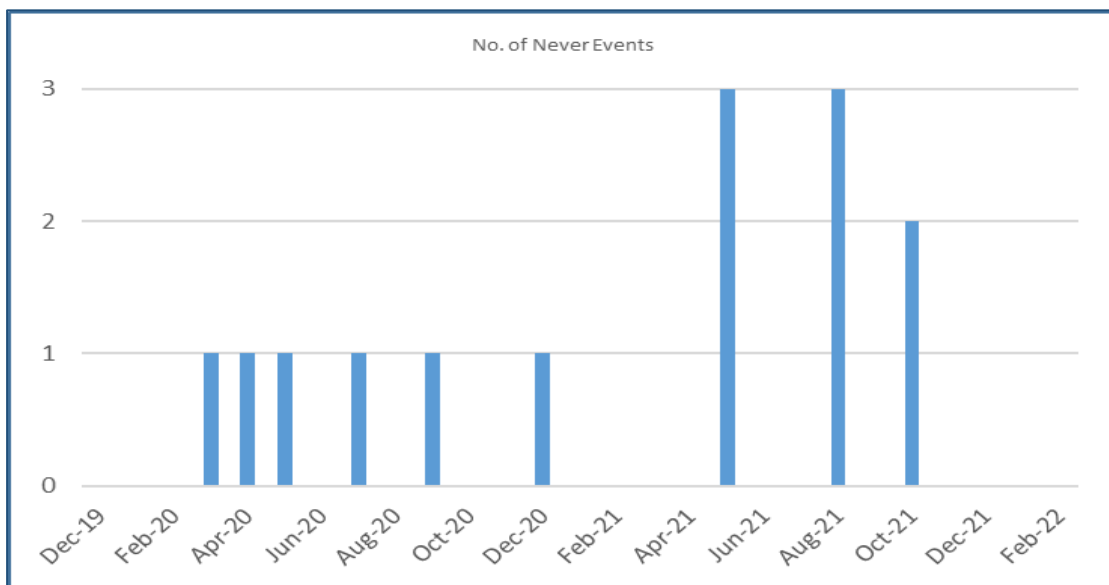
**Trend based on comparison to cumulative April to December 2021/22 and 2020/21

Quadruple Aim 4: Incidents (Reportable)



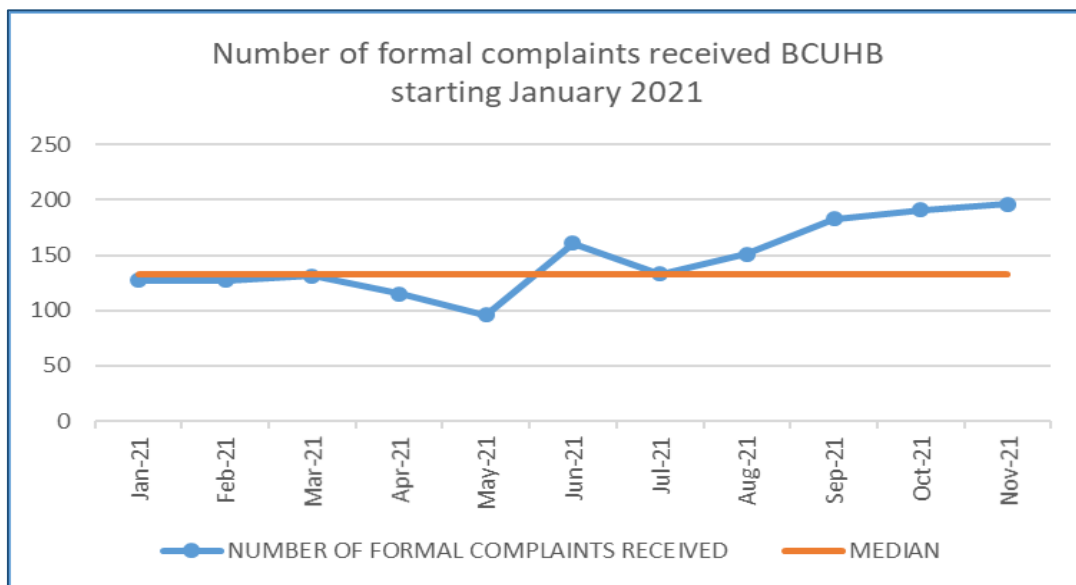
- Reporting levels from June 2021 reflect the changes in reporting criteria as detailed in Phase 1 of the NHS Wales National Incident Reporting Policy, in particular the requirement to report only falls resulting in severe (i.e. permanent) harm. During 2020/21 there were also several changes to reporting criteria by Welsh Government due to COVID-19. Therefore, comparison pre-June is not possible.
- An increase in the number of incidents reported in November (n=11) is due to a backlog of 5 Healthcare Acquired Pressure Ulcer (HAPU) incidents reported retrospectively following investigation (10 avoidable HAPUs were reported). These HAPU incidents are only reported on conclusion of the investigation.
- The percentage of nationally reportable incidents that have been closed on time has been deteriorating since May 21. However a review of process and improved monitoring of the progress of investigations has resulted in a marked improvement in performance in November 2021. Additional capacity is being identified to support services during the winter period.

Quadruple Aim 4: Incidents (Reportable)

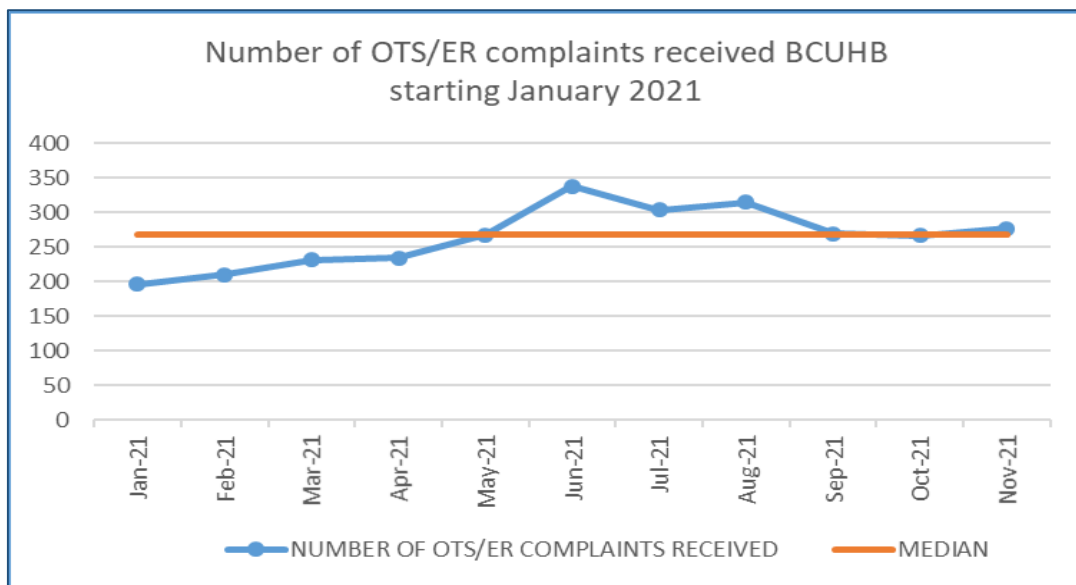


- 2 New Never Events occurred in Oct-Nov 2021 (compared to 1 during the same period of 2020)
 - Retained object following surgery.
 - Retained swab following birth
 - There are work streams under development to address the increase in Never Events to include work around WHO checklist. An All Wales Never Event: Invasive Procedures and Human Factors Symposium was held recently with attendees and representation from Health Board. Learning from this event will be shared.
 - Further detail is included in the Patient Safety Report.
- *please note that a further never event has been **reported** to the DU in this period following confirmation that an incident from August 2021 could be classed as a never event.*
- The number of falls reported with harm (categorised as moderate, major and catastrophic within the incident reporting system) has remained stable. There are a number of interventions taking place including a strategic falls group looking at training, reviewed policy and measurement.

Quadruple Aim 4: Complaints

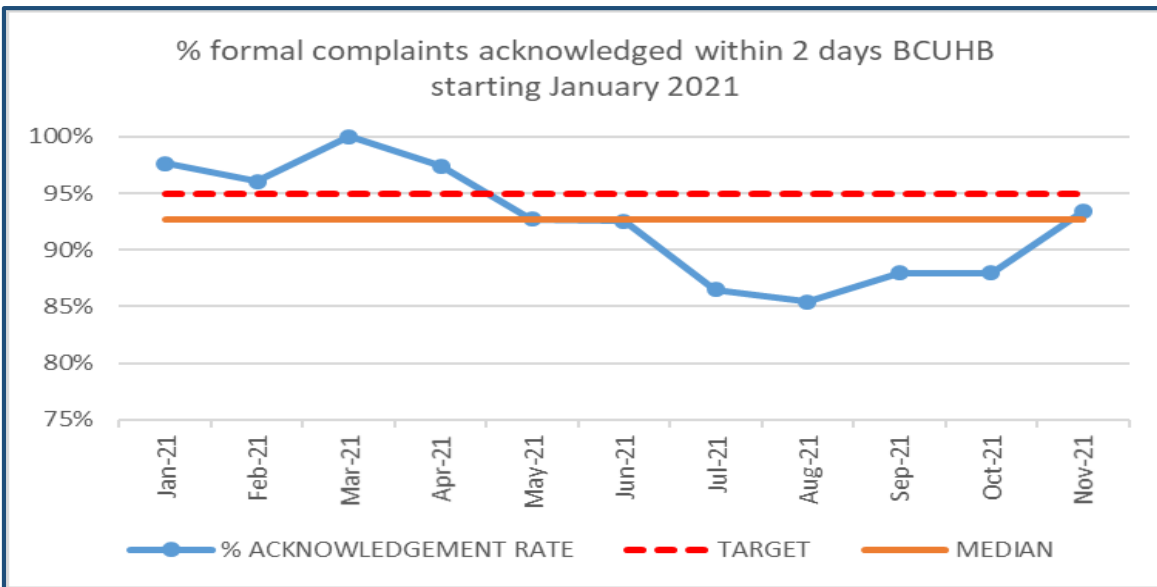


- There has been an increase in the number of formal complaints received in October and November, following a trend analysis many of these relate to secondary care waiting times, access and care delivery issues.

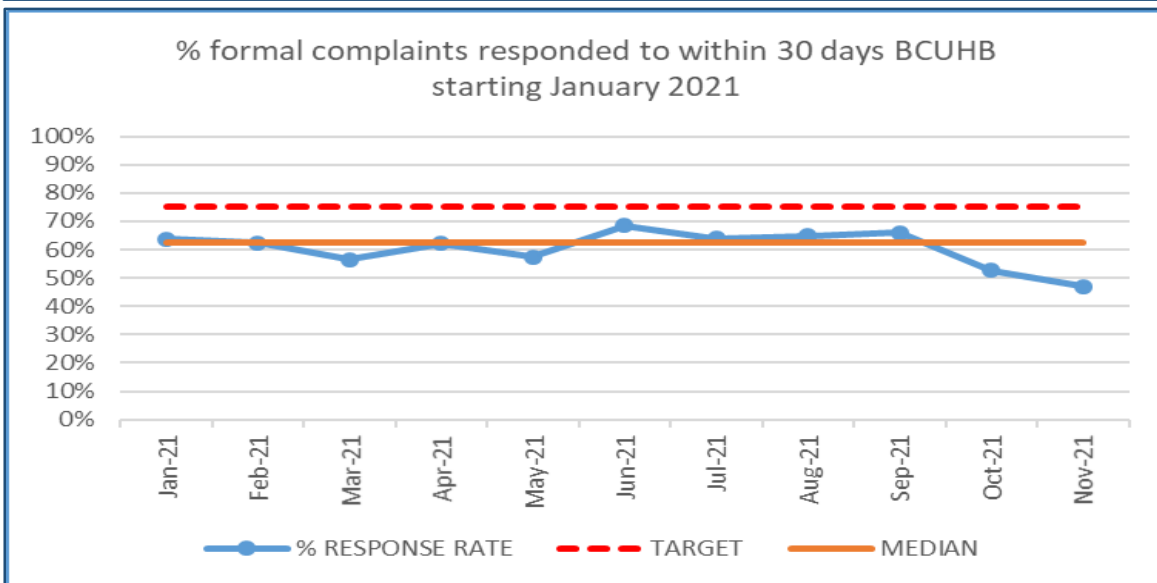


- The number of Early Resolutions (ER) is consistent with previous data. The number upgraded to Formal complaints remains low. This demonstrates the proactive approach by the Complaints Team and services to resolve Early Resolutions in a two day time frame (for those that do not allege harm).

Quadruple Aim 4: Complaints

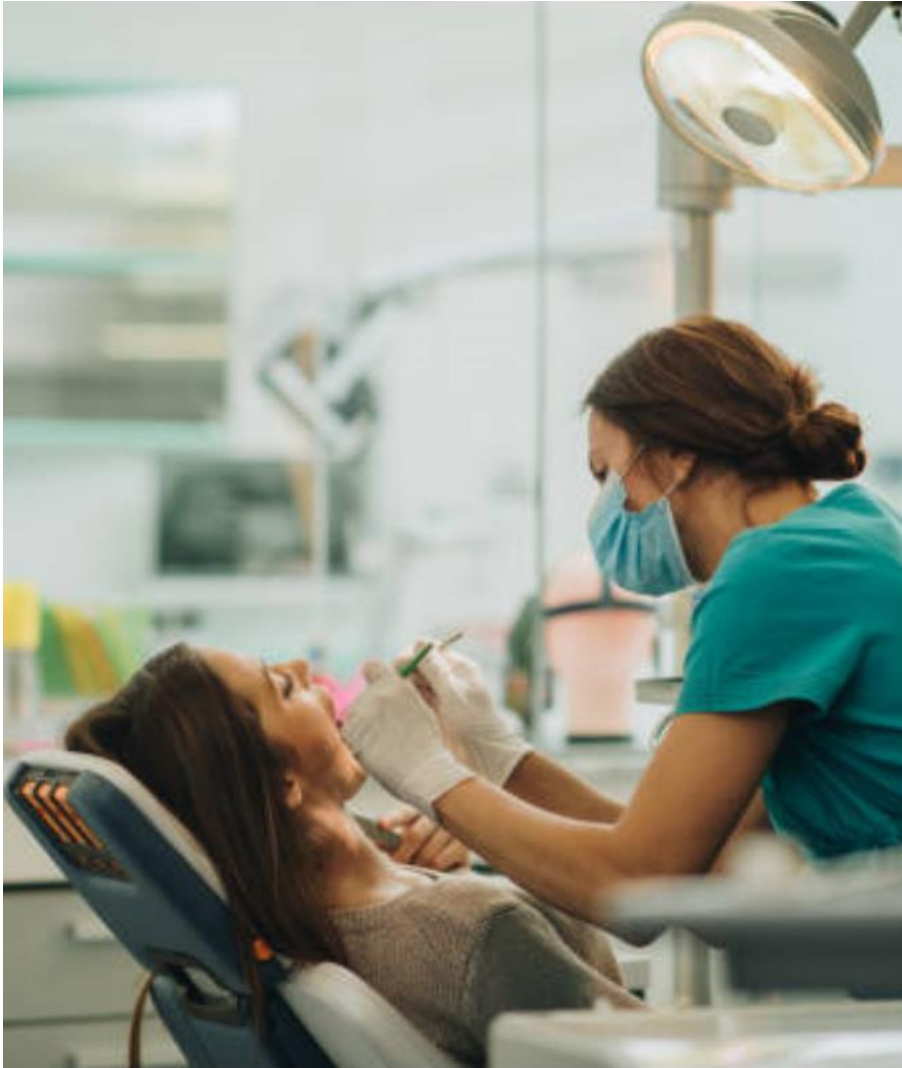


- There was a marked improvement in the number of 2 day acknowledgements in November at 93.37%. Previous performance in this area has been high and tight scrutiny remains in place to recover the position.



- The 30 day performance target is below 2020 and remains below the 75% target set by Welsh Government, this is due to number of factors including an increase in the volume of Formal Complaints received, pressures of the COVID-19 pandemic and the capacity within services to investigate complaints. Additional capacity has being identified to support services during the winter period. Meetings with MP/MS and improved bespoke communication approaches are being trialled in December and January to see if that reduces the number of formal complaints.

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
Sep 21	Crude hospital mortality rate (74 years of age or less)*	Reduction	0.94%	↑
Nov 21	Percentage of in-patients with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening**	Improve	60.00%	↓
Nov 21	Percentage of patients who presented to the Emergency Department with a positive sepsis screening who have received all elements of the 'Sepsis Six' first hour care bundle within one hour of positive screening**	Improve	15.38%	↓
Oct 21	Percentage of patients (age 60 years and over) who presented with a hip fracture that received an orthogeriatrician assessment within 72 hours *	Improve	61.00%	↑
Oct 21	Percentage of episodes clinically coded within one reporting month post episode discharge end date	Improve	91.00%	↓

* Rolling 12 months reported 1 month in arrears

**Reported 1 month in arrears

*** Concerns re data quality remains and data should be viewed with caution.

Quadruple Aim 4: Narrative - Mortality

The 12 month rolling crude mortality rate for ages 75 years and under is below the peer group (0.94% v 1.06% (Other Welsh HBs ex Powys) to September 2021). This is similar to the previous months; COVID-19 infections have lessened (8% less than last year). However, the highest number of deaths was in those patients admitted with COVID-19 (130↑), Sepsis (102↑) and pneumonia (84↑ – lobar and unspecified).

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

- Crude mortality- overall (2.07% v 2.36%) this is similar to previous year.
- Mortality- sepsis (18.42% v 20.34%) remains below the peer; variation seen over the past year is common cause with mortality “as expected” overall.
- Mortality- cerebrovascular disease incl. stroke (12.06% v 12.67%) variation seen over the past year is common cause with mortality “as expected” overall.

Actions being taken

- Work is in progress to clear the backlog of stage 2 reports; with more than half being able to be closed without further mortality review as they relate to complaints/ Coroners referrals or are within the PTR system and so have already been investigated in an alternative way. This is being progressed by the lead consultant.
- A process has been developed to introduce the new mortality review framework; this will require additional administrative support currently being sought. The plan is to pilot this within YG during January to test the system. It will require the new Datix mortality module to be available to support the process.
- The Medical Examiner Service has started on the Wrexham Maelor site and aims to be fully in place by the end of January (subject to ME capacity). There is a new mortality lead on this site (Dr Sam Sandow)
- The Business Case for the Clinical Effectiveness Department was agreed with the services at a workshop earlier this month; it is included in the IMTP and is ready to for discussion with the Executives.

Timelines

- Learning from Deaths Policy and process – this will be updated by March 2022 when the framework is in place.

Quadruple Aim 4: Narrative – Mortality (2)

Risk

- Lack of agreed mortality review process across all acute sites may result on the three areas working differently. Mitigation - all sites are using the same tools. Working towards delivering the national framework by Mar 2022 across all sites
- Failure to complete mortality reviews in a timely way, means learning is not identified or shared and this could lead to patient harm and loss of organisational reputation. Site-based reporting has been put in place to ensure all sites are aware of the pending stage 2 reviews. Mitigation - Sites all have processes in place to complete reviews. Those reported through the Putting Things Right system or to the Coroner have a robust governance system to monitor action plans and share learning. A quarterly report is in place that highlights the concerns raised by the Medical Examiners Service to enable thematic review.

Quadruple Aim 4: Narrative – Timely Interventions - Sepsis

Issues Affecting Performance

- Data collection has been addressed within the Emergency Department (ED) at YG, but not on the other sites. Inpatient data is very poorly captured across all sites.
- The sepsis tool is being updated. The replacement tool is from the Sepsis Trust and the Welsh version that excludes the updated NEWS tool (used in England) is awaited. There are new sepsis books required on each site to support the implementation. There have been clinical engagement within YGC.
- Long ambulance waits, delays in Emergency Dept. doctor reviews and sometimes lack of nurses contribute to delays in diagnosis and treatment in YG. This particularly affects the ability to provide antibiotics within an hour of diagnosis.
- The Symphony system in ED requires real time data entry; staff have been made aware of this.

Actions and Outcomes

- All sites are aware of this issue and it has been escalated through the governance systems.
- YG: data are being monitored through the accountability process; AMD (QS&E) new chair of Stop Harm Intervene Early Limit Deterioration (SHIELD) group in the New Year; on going education and awareness raising for new staff.
- YGC - piloting the new tool in Ed continues. Recruiting sepsis champions – however, staff do not feel able to take on additional roles at the current time due to the staff shortages on the wards and relatively high number of locum staff..
- YWM has identified sepsis champions for all clinical areas that will start to support a programme led by Acute Intervention Team; sepsis bundle included in local teaching with additional targeted education focussing on new starters.
- Sepsis bundle to be included in the electronic nurse documentation (national development)
- Adoption of the new tool has been delayed as there are co-dependencies required including amendment to the current TPR chart and the need for project management support. Karen Mottart is supporting Craig Beaton to progress this.

Timeline for delivery of improvement

- Action plan to the Interim Deputy Medical Director by Jan 2022
- Widespread adoption of a new sepsis tool will be dependent on additional resources and is currently being explored

Risks and Mitigations

The risk is the organisation is not sighted on Sepsis 6 bundle compliance because of poor data capture. Where data is reported compliance is low (circa 30% total bundle compliance); these are time critical interventions and delays within ED impede delivery. Delays in treatment are associated with additional morbidity and mortality. The data are also reported externally to Welsh Government and failure to report may cause reputational damage. At the current time mortality from sepsis is within expected limits and below the Welsh average peer group in the Comparative Healthcare Knowledge System (CHKS). There has been a run of above average monthly crude rates in YGC from Jan - August 2021.

Mitigation: There is education and awareness raising in all ED departments; triage processes are in place that will identify the deteriorating patient regardless of cause and should support early escalation for treatment.

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

Quadruple Aim 4: Narrative – Timely Interventions – Orthogeriatrician Review

Issues Affecting Performance

- YG – The compliance year to end of October 2021 was 61% against a average of 88% . Lack of Ortho-Geriatric cover due to consultant shielding and sickness are a concern.
- YGC The compliance to the end of October was 91%. There is a full time physician in this role and a dedicated Physicians Associate attached to Ortho-Geriatrics.
- YWM- overall orthogeriatrician review within 72 hours for patients over the aged of 60 with Neck of Femur (NOF) / proximal femoral fractures sits at 72% for the 12 month period to October 2021 (includes time period with no orthogeriatrician cover because of COVID-19 but this is reaching the end of its time lag). Monthly trend upwards (especially since additional consultant sessions since April 2021) with most recent monthly figure >80%. Risk remains that there is no formal cover plan in situ for leave etc.

Actions and Outcomes

- YG - Limited sessional cover secured for planned annual leave (10 sessions/year of Care of the Elderly (COTE)). Discussed at site accountability meeting. Aim to revise initial COTE job description to more bespoke once received.
- YGC – no additional actions. Continue to support the team to find cover for annual leave.
- YWM - no additional actions.

Timeline for delivery of improvement

- YGC Business case with HMT for approval of a middle grade to support the Orthogeriatrician; outcome expected by January 2021.

Risks and Mitigations

- The risk is that patients' health is not maximised before surgery and comorbidities not managed well peri-operatively with the potential for avoidable morbidity and mortality. Performance has improved over the past 3 years across the Health Board with additional resources.

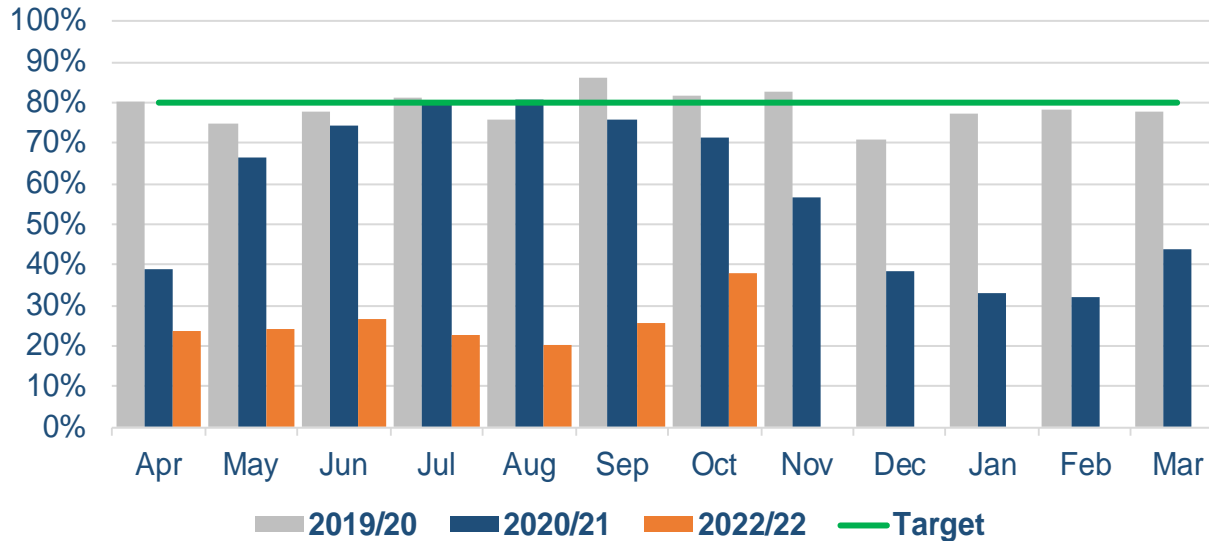
YG = Ysbyty Gwynedd YGC = Ysbyty Glan Clwyd YWM = Ysbyty Wreccsam Maelor

Period	Measure	Target	Actual	Trend	Period	Measure	Target	Actual	Trend
Q2 2021/22	Percentage of Health and Care Research Wales non-commercial portfolio studies recruiting to target		52.00%	↓	Q1 2021/22	Number of patients age 65 years or over prescribed an antipsychotic	Reduction	2,451	↓
Q2 2021/22	Percentage of Health and Care Research Wales portfolio commercially sponsored studies recruiting to target		14%	↓	Q1 2021/22	Number of women of child bearing age prescribed valproate as a percentage of all women of child bearing age		0.144%	↑
Q1 2021/22	All new medicines recommended by AWMSG & NICE, must be made available where clinically appropriate, no later than 2 months from appraisal recommendation.		99.30%	↑	Q1 2021/22	Opioid average daily quantities per 1,000 patients		4,801.7	↓
Q1 2021/22	Total antibacterial items per 1,000 STAR-PUs	< 207.1	221.8	↑	Q1 2021/22	Quantity of biosimilar medicines prescribed as a percentage of total 'reference' product including biosimilar (for a selected basket)		92.70%	↑
Q1 2021/22	Percentage of secondary care antibiotic usage within the WHO Access category	< 55%	N/D*	N/A	* Welsh Government Data not published at the time of reporting				

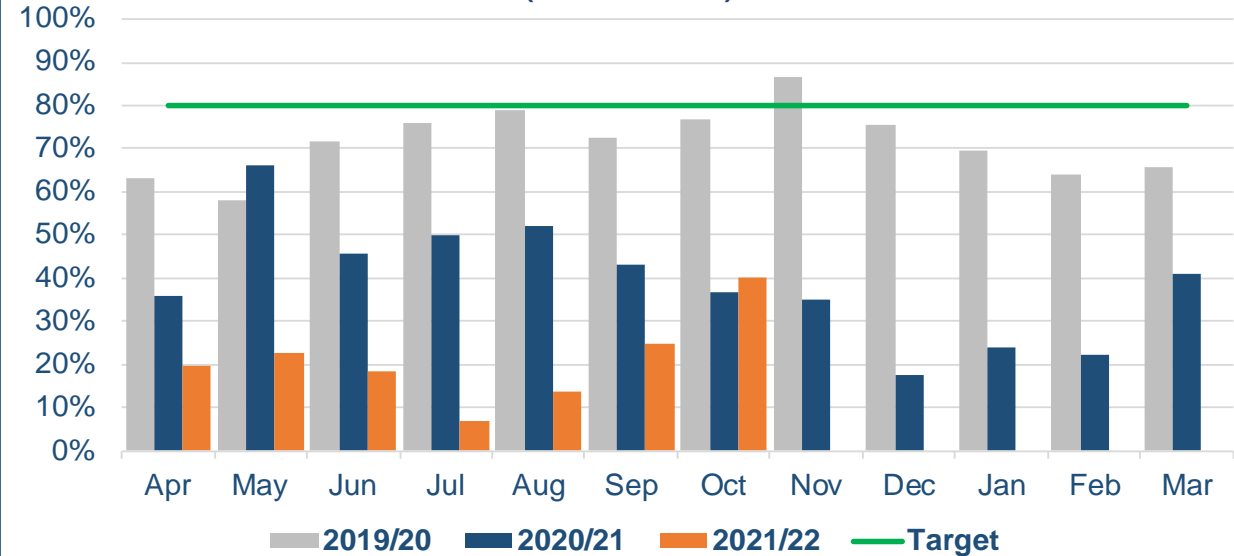
Additional Information

Quadruple Aim 2: Charts CAMHS

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

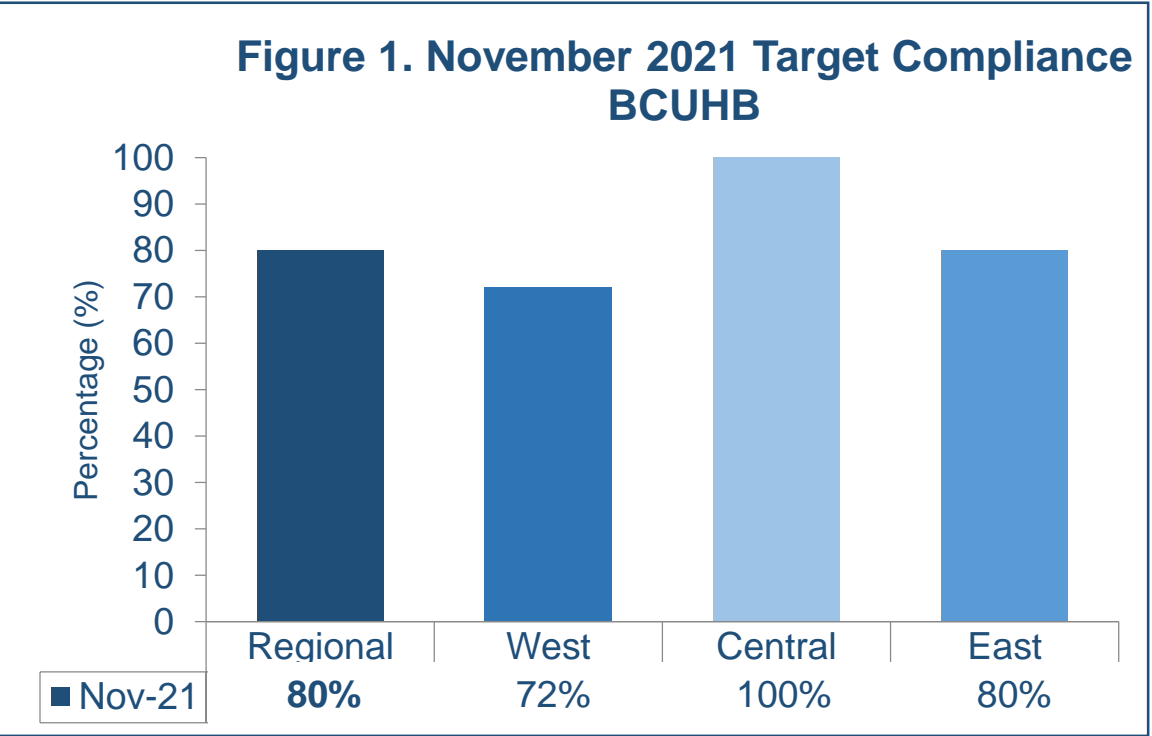
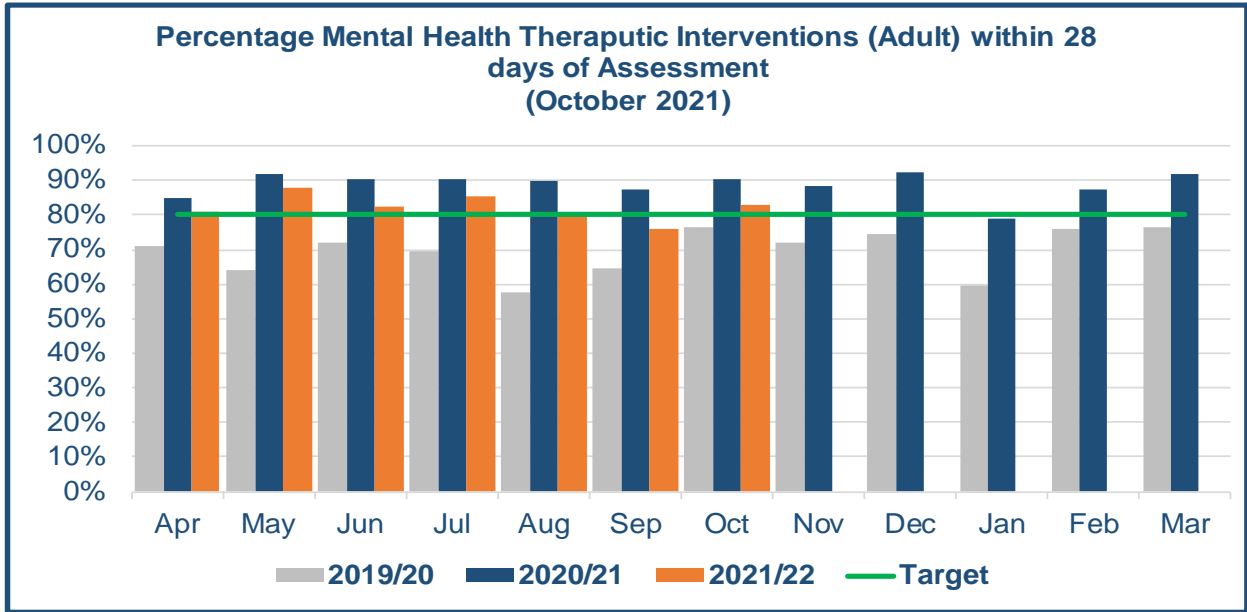
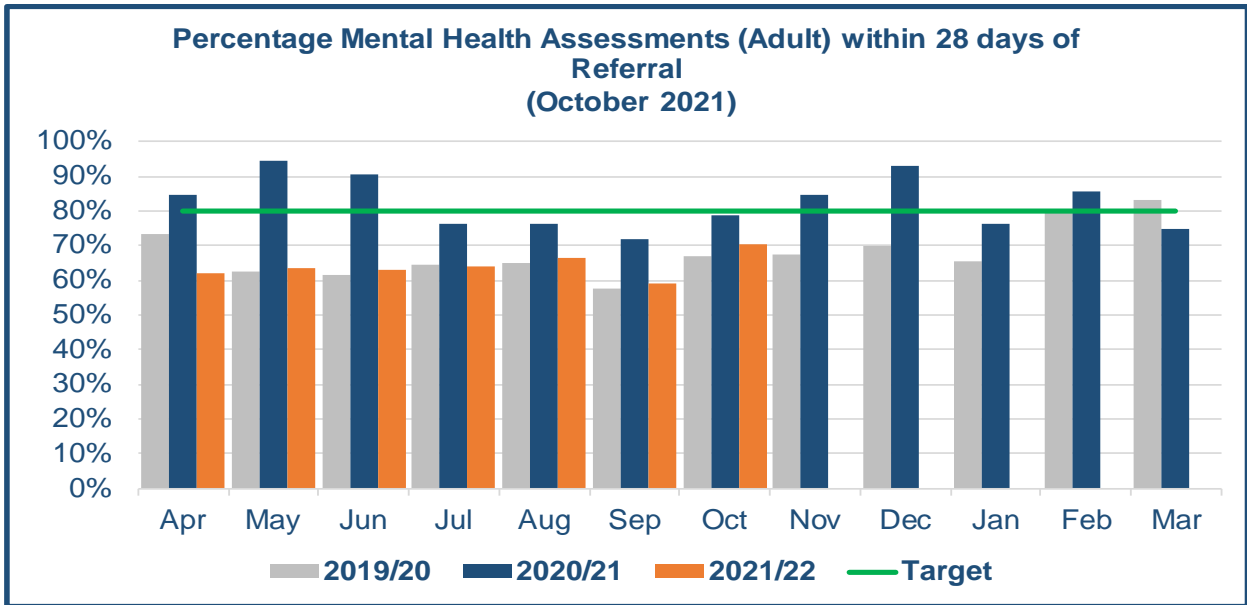


Percentage Mental Health Therapeutic Interventions (CAMHS) within 28 days of Assessment (October 2021)



Data is reported 1 month in arrears

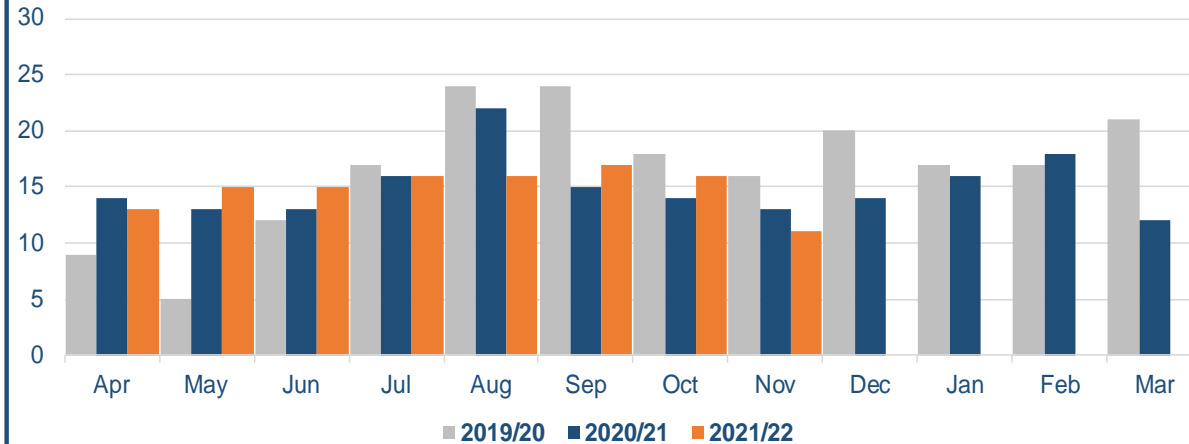
Quadruple Aim 2: Charts Adult Mental Health



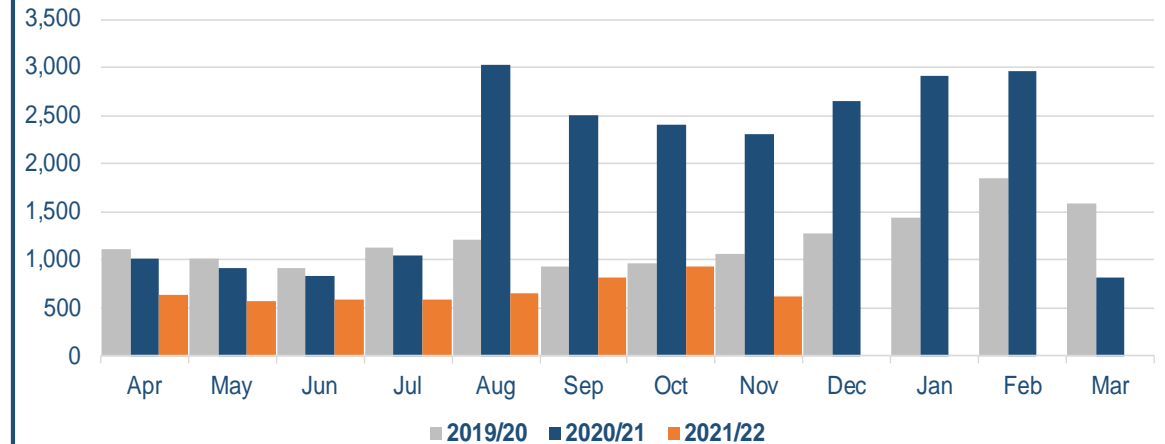
Assessments and Interventions data is reported 1 month in arrears

Quadruple Aim 2: MH Delayed Transfers of Care

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

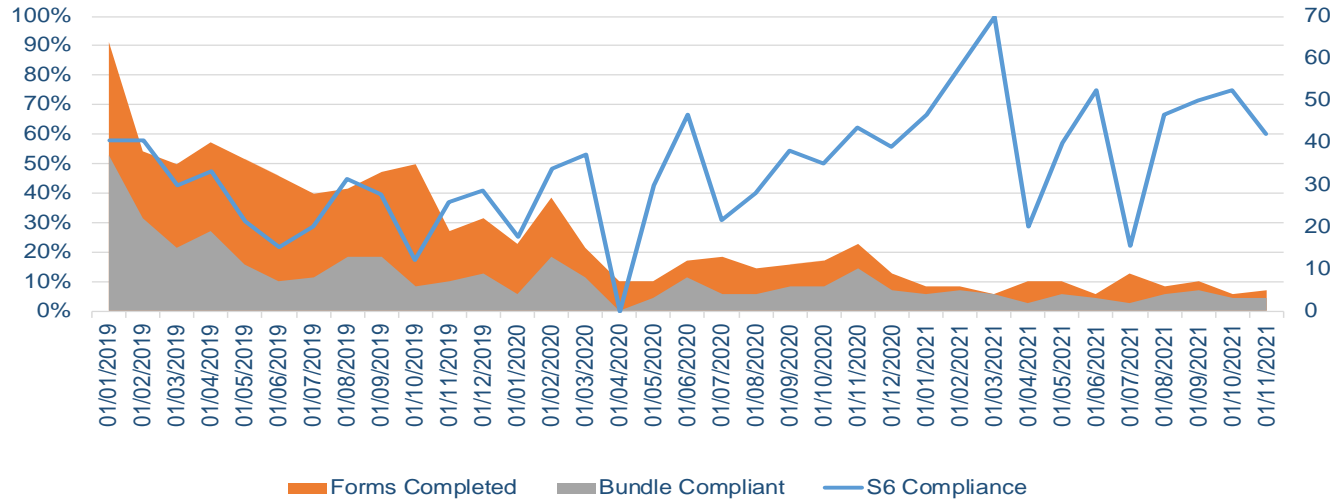


Number of Delayed Bed Days (BCU Mental Health)
 2021/22 comparison to 2020/21 and 2019/20
 November 2021



Quadruple Aim 4: Sepsis Six Bundle Performance

Inpatients - 1 Hour Compliance Sepsis Six Bundles



Important Note:

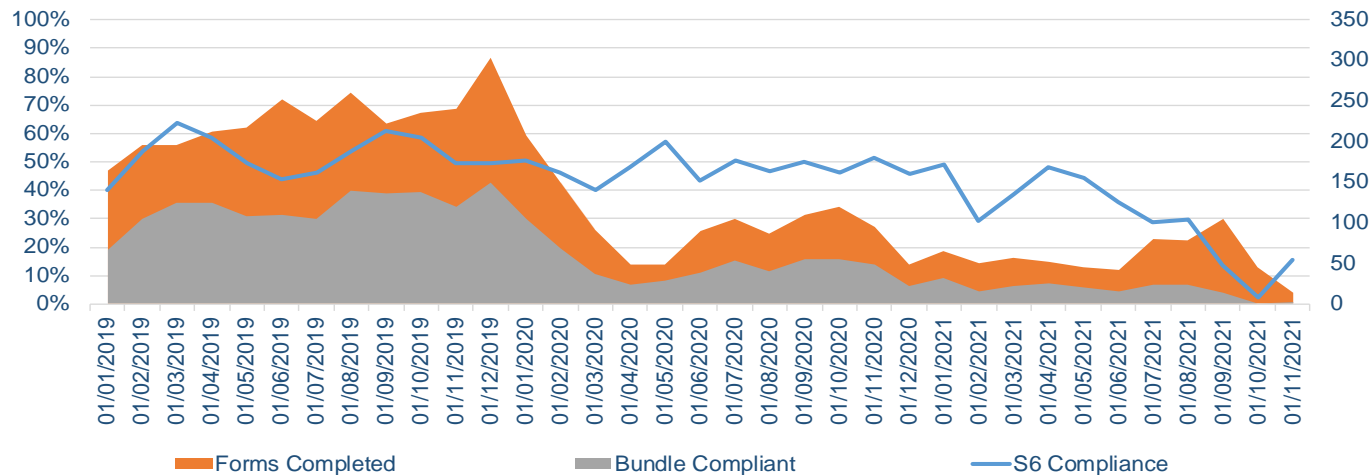
The blue line in these two graphs represent the % compliance with Sepsis Six Bundle provision within 1 Hour of suspicion of a sepsis infection.

The orange 'area' represents the total number of Sepsis Six Forms that were completed.

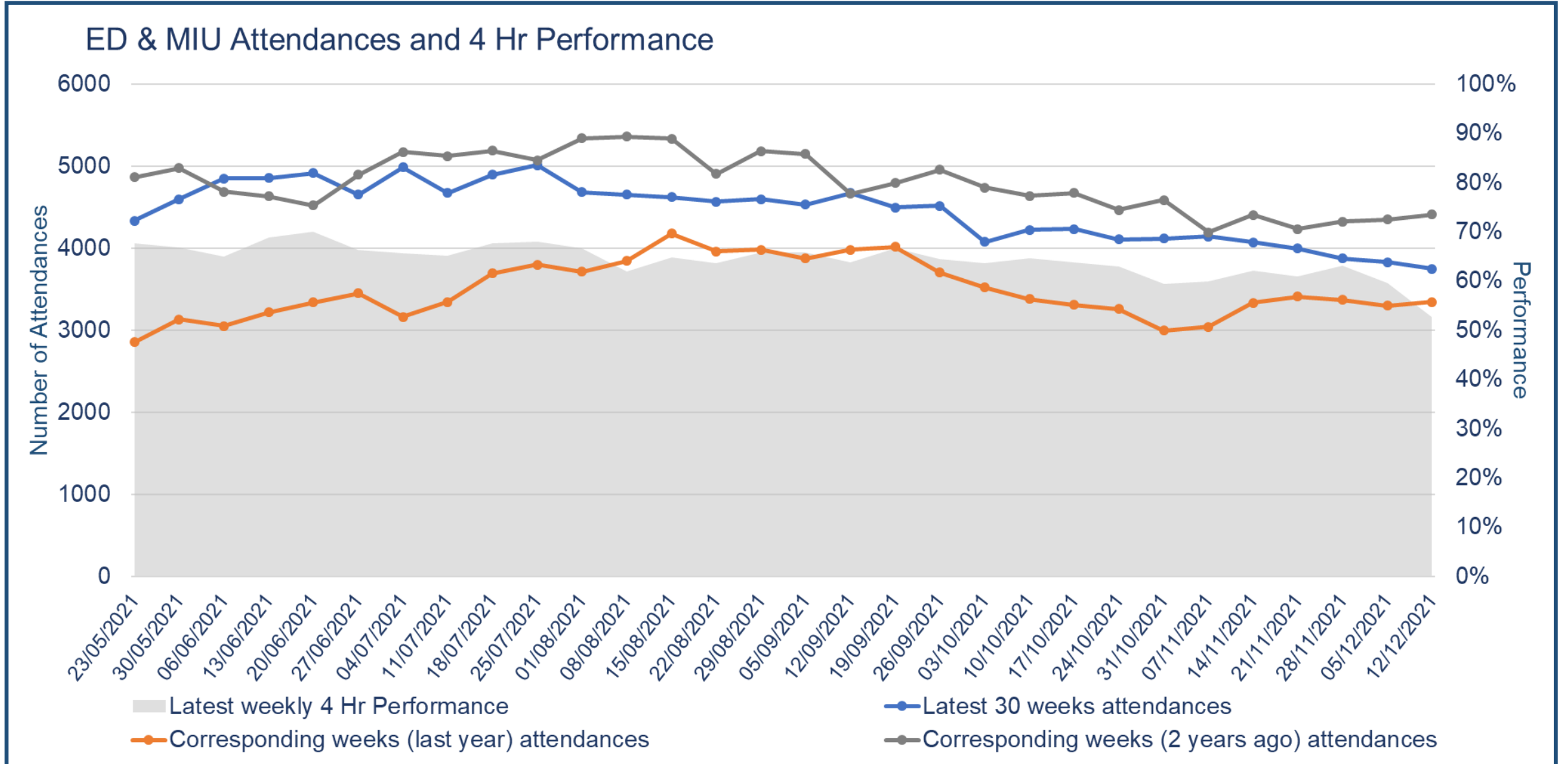
The Grey 'area' represents the total number of forms completed where they were compliant with the Sepsis Six Bundle measure.

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.

Emergency Departments - 1 Hour Compliance Sepsis Six Bundles



Impact of COVID-19 Pandemic on Unscheduled Care



Impact of COVID-19 Pandemic on Unscheduled Care

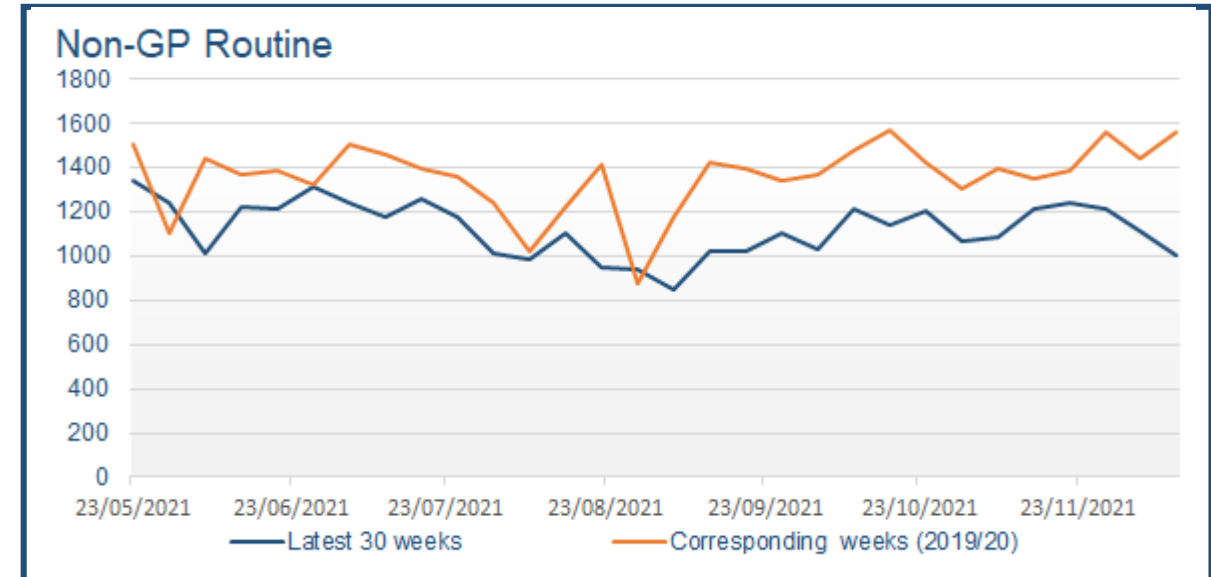
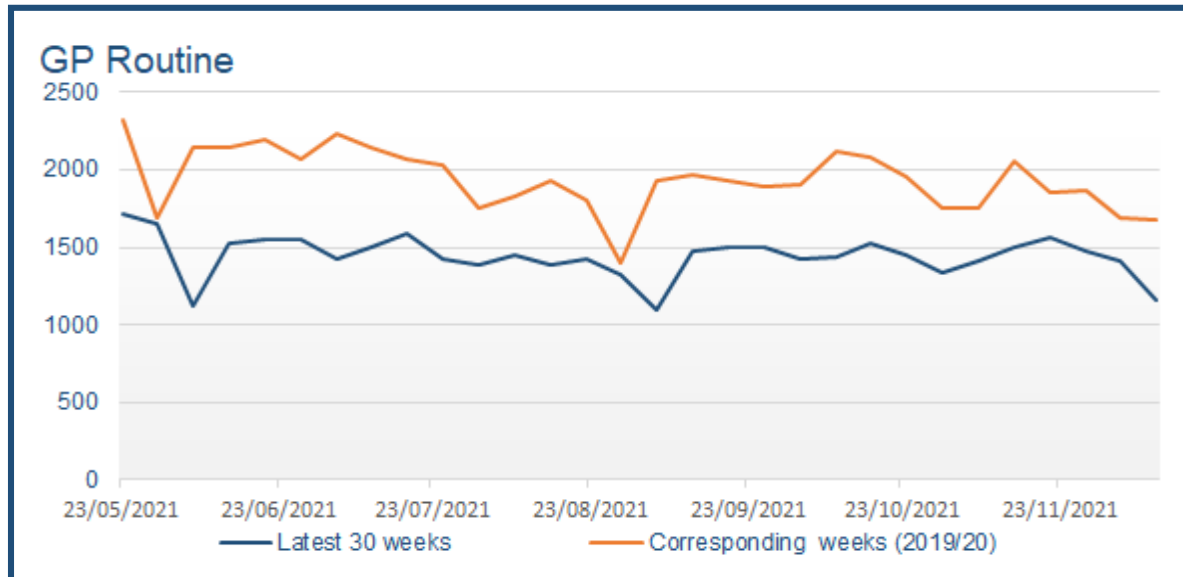
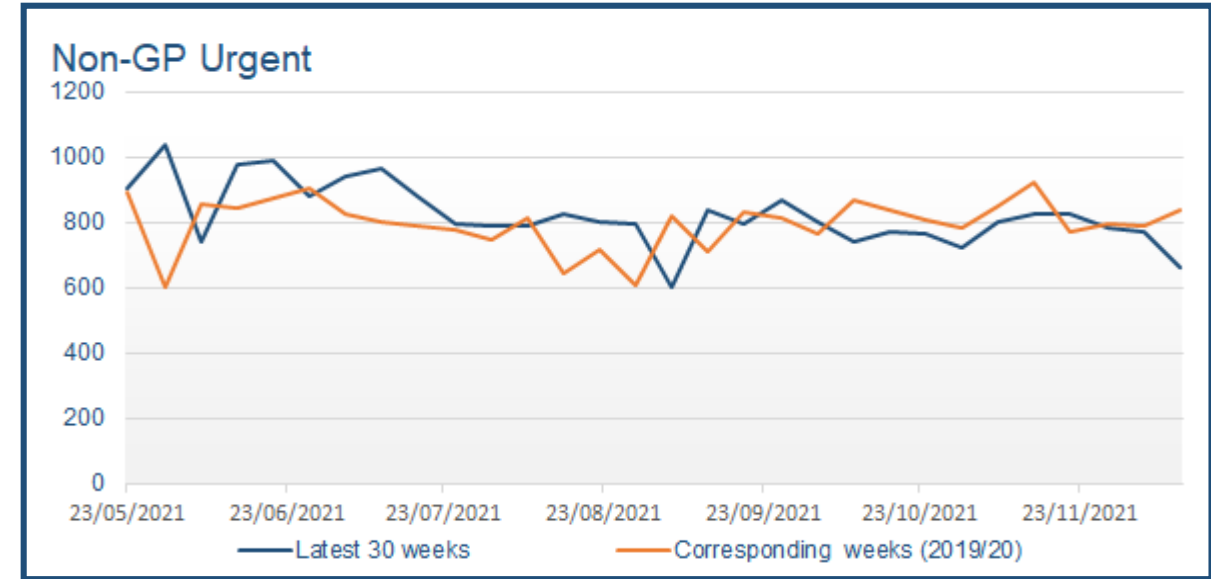
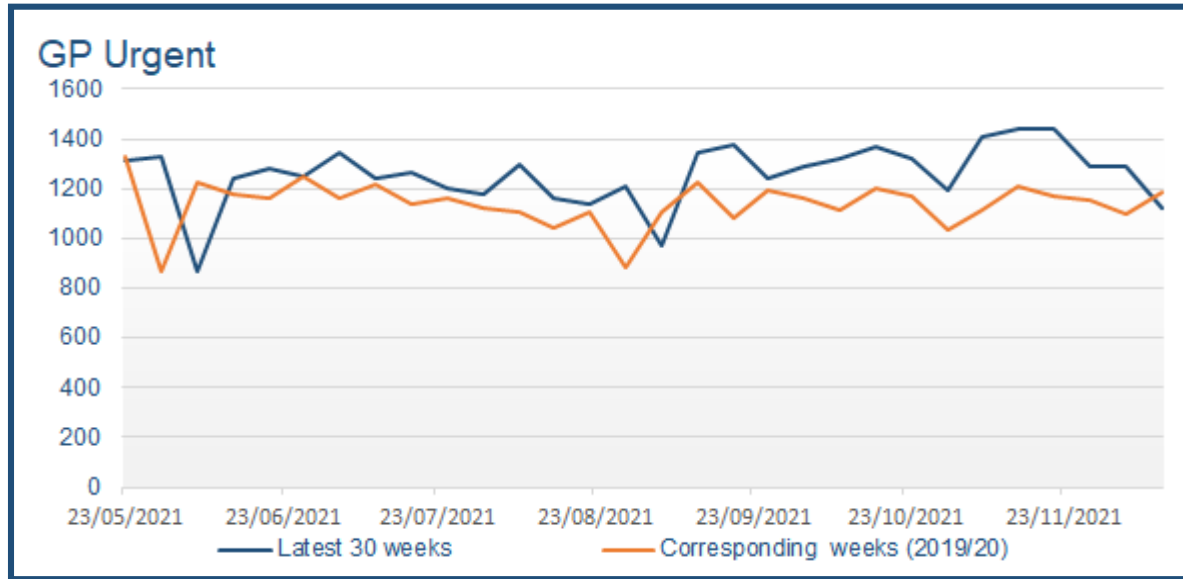
Unscheduled Care Performance by Site 6th December - 12th December 2021

Measure	West	Centre	East	BCU
ED&MIU Number of Attendances	1085	1411	1253	3749
ED&MIU 4 Hour Performance	53.36%	63.64%	39.58%	52.63%
ED Number of Attendances	887	1016	1084	2987
ED 4 Hour Performance	43.52%	49.70%	31.18%	41.14%
ED 12 Hour Performance	171	220	263	654
1 Hour Ambulance Handover Breaches	149	179	110	438
Red 8 Minute Ambulances	51	51	72	174
Red 8 Minute Performance	43.14%	50.98%	47.22%	47.13%

Red 8 Minute Ambulance data is unvalidated and not for sharing outside this report

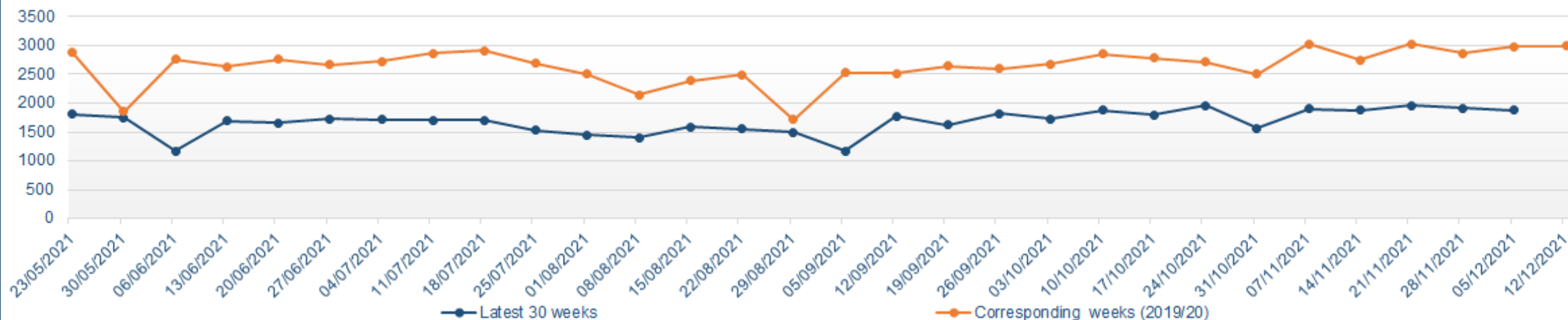
Sources: Red 8 Minute - WAST Health Board Area Report; ED and Handover - IRIS, accessed 13/12/2021

Impact of COVID-19 Pandemic on Referral Rates

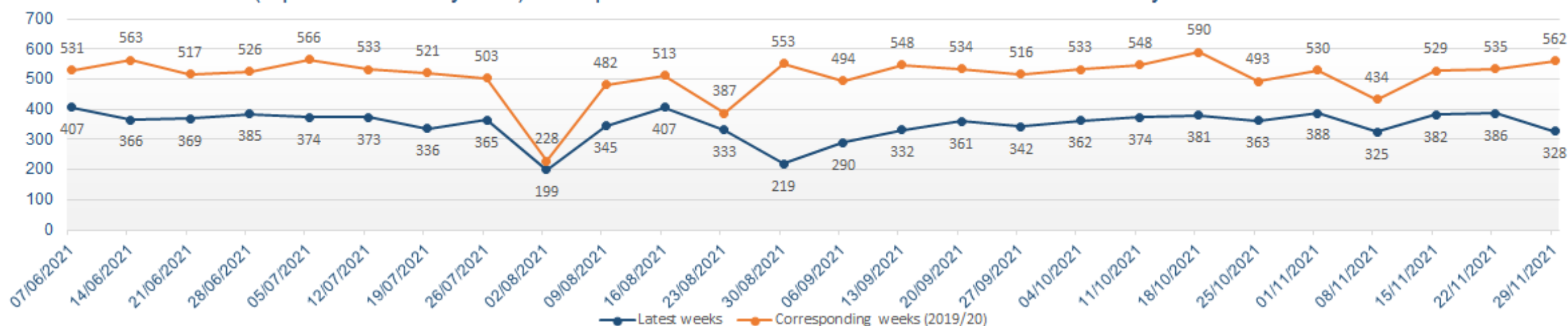


Impact of COVID-19 Pandemic on Planned Activity

RTT High Level Report - Core Outpatient Activity (new, RTT, face to face attended appointments) *data currently unavailable for



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



Further Information

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

- tolerances for red, amber and green

Further information on our performance can be found online at:

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

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

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Patient Safety Report						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance Sarah Musgrave, Patient Safety Lead Manager Shan Kennedy, Redress and Claims Lead Manager Debbie Kumwenda, Inquests Lead Manager						
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO Matthew Joyes, Acting Associate Director of Quality Assurance						
Atodiadau Appendices:	1. Patient Safety Report						
Argymhelliad / Recommendation:							
The Quality, Safety and Experience Committee is asked to note the report.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	✓	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
The Quality, Safety and Experience Committee is the delegated Health Board Committee with responsibility for seeking assurance on patient safety. This report provides the Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.							
Cefndir / Background:							
This report is designed to offer improved information and analysis in relation to patient safety, in order to improve the assurance received by the Committee. The period under review is primarily October to November 2021 (inclusive); however, longer-term data (allowing month on month comparison) has been included in the graphs to provide a better longitudinal view and to enable the use of statistical process control (SPC) charts.							
Asesiad / Assessment & Analysis							
Assessment and analysis is included within the report including a breakdown of incidents by division/site, details of the most common type of reported serious incidents and a high-level summary of identified learning.							

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered - Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – This is contained within the report.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – This is contained within the report.

Asesiad Effaith / Impact Assessment – Impact assessments are not required for this report.

Patient Safety Report October and November 2021

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

INTRODUCTION

The work of the Patient Safety and Experience department is focused on the prevention of harm to patients by improving the way in which care is delivered so that errors are prevented, ensuring that 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.

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.

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

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

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 Patient Safety and Experience Department manage these matters,

they are included in this report to provide an overall view of these areas; however, relevant information is also included in the Occupational Health and Safety Report.

NATIONALLY REPORTABLE INCIDENTS

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 Corporate Patient Safety and Experience Department has regularly met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

The DU accepted the definitions as laid down by the Welsh Government and the reporting criteria:

As of the 14th June 2021, NHS Wales' responsible bodies were required to implement Phase 1 of the Welsh Governments 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 14th 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 "

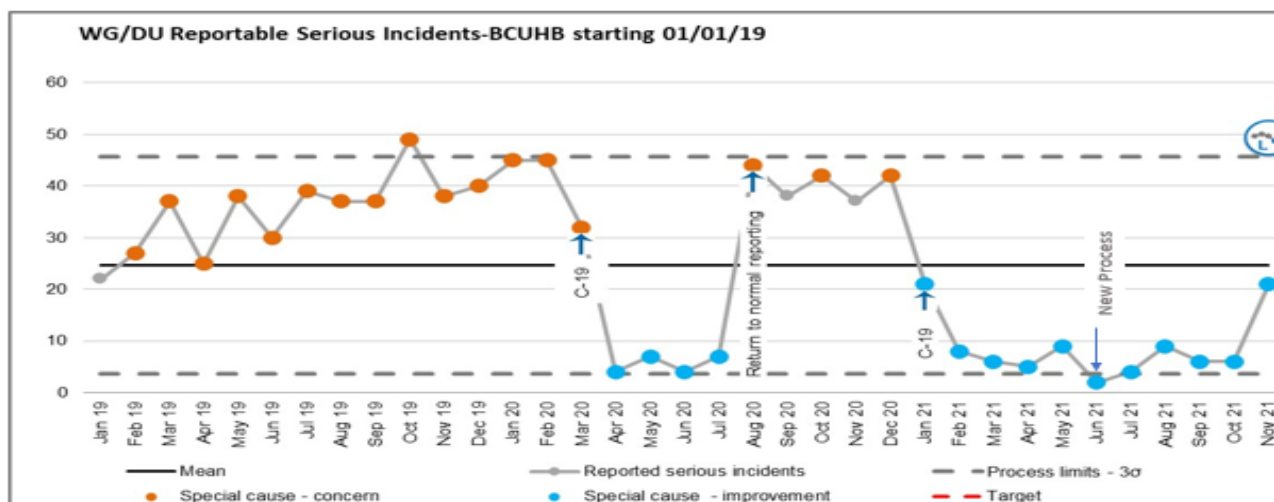
The timescale for reporting such incidents has increased from 24 hours to within seven working days.

The Delivery Unit has lifted any reporting restrictions that were put in place because of Covid-19 as of the 14th June 2021, and provided a list of Specific National Incident Categories as well as Specific Reporting Arrangements.

Further details around changes to National Incident Reporting in NHS Wales can be found on the Delivery Unit website:

[Patient Safety Incidents - Delivery Unit \(nhs.wales\) Phase 1 Policy Guidance Document v1.0.pdf](#)

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



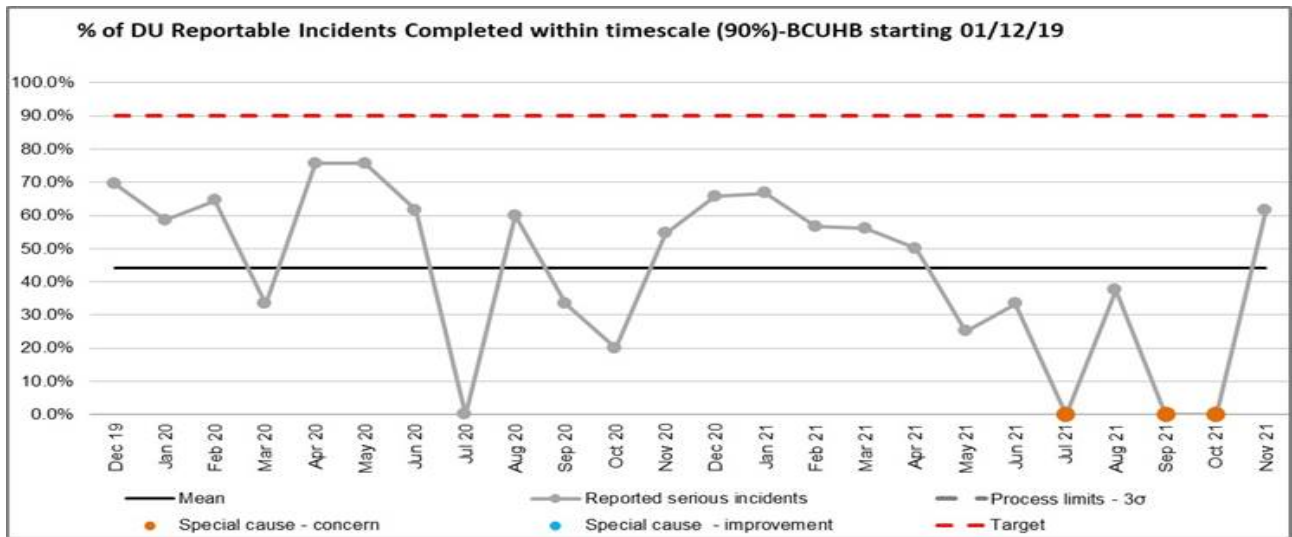
During the time period under review, 27 nationally reportable incidents occurred, three of which were Never Event incidents. This is an increase in nationally reportable incidents from the August/September figure of 15. The increase in nationally reportable incidents is due to the retrospective submission of ten avoidable Grade 3, 4, and unstageable hospital acquired pressure ulcers (HAPU) closure forms. The reporting of avoidable Grade 3, 4 and unstageable HAPUs is not undertaken until the investigation is completed and a decision reached on whether avoidable or unavoidable, therefore reporting of HAPUs is always completed retrospectively and this number reflects the resumption of reporting from 14th June 2021.

There were seven Early Warning Notifications (EWN) reported, three of which were Procedural Response to the Unexpected Deaths in Childhood (PRUDiC) related.

At the time of writing, 57 national reportable incidents remain open with the Delivery Unit of which 34 are overdue. The total number of open incidents has increased from 49 in September; however, the number that are overdue has increased by two (to 34).

At the end of November 2021, 27 legacy serious incidents (i.e. those reported prior to June 14th 2021) remain open with the Delivery Unit. Of these, the predominance of overdue incidents relates to Corporate Safeguarding (all PRUDiC) (11), West Acute (5), Central Acute (3), Cancer Services (3), Womens (1) and MHLDS (3). A piece of work is currently ongoing with the Welsh Government and all Health Boards across Wales, to consider how best to manage the nationally reportable historical serious incidents which remain open within individual organisations up to 13th June 2021, when the new incident reporting policy became operational. The Welsh Government are now looking to complete that work pragmatically, taking account of the age of some of the incidents and what learning can be drawn from them.

Overall closure rate within timeframe for the year is around 62%, a return to an improved level of compliance compared to previous 9 months.



NATIONALLY REPORTED INCIDENTS

There were 27 nationally reported incidents, including **three** Never Events, in total for the two-month time period. The table below shows immediate learning, and where a Rapid Learning Panel was held, the learning from that process. It is important to note investigations are underway for all incidents below which will result in improvement plans.

As part of the new incident process, Rapid Learning Panels take place between the senior service team and Executive Directors within 24-72 hours 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 update on immediate learning and actions being taken, identify key risks and provide support where required.

During October and November, 7 Rapid Learning Panel meetings took place. Those Nationally Reported Incidents that were also subject of a Rapid Learning Panel are indicated below (RLP), and actions and learning are noted.

The immediate learning column reflects the learning at either the 24-hour Rapid Learning Panel and/or the 72 hour Make it Safe Review. It is therefore focused on immediate learning for the clinical teams. In all cases, detailed investigations are underway which will produce improvement plans against the findings.

Wrexham Maelor Hospital – Acute (7)

Location	Incident		Immediate Learning
Emergency Department	Delay in diagnosis and transfer to specialist care (vascular). Patient underwent leg amputation	RAPID LEARNING PANEL <ul style="list-style-type: none"> • Delay in review of clinical investigations of 12 hours. • Reinforce the importance of effective handovers • Impartial IO (identified) and external vascular expert required (not confirmed) 	Lack of timely assessment of a patient with acute vascular injury can result in poor outcome Confirmation from vascular lead that Diagnosis can be made on clinical presentation and history i.e. without CT angiogram, to prevent delay in transfer to Ysbyty Glan Clwyd (YGC)

Location	Incident	Immediate Learning
Bonney Ward	Pressure sore Grade 3 (reported June 2021, open and closure form submitted November 2021)	Failure to identify and risk assess skin integrity and existing broken skin areas on admission and throughout patients' journey
Fleming Ward	Pressure sore – unstageable/unclassified (reported August 2021, open and closure form submitted November 2021)	Ensure that the appropriate risk assessments are completed and all identified actions with referrals are followed consistently
Bersham Ward	Pressure sore Grade 3 (reported June 2021, open and closure form submitted November 2021)	Delays in intentional rounding, inaccuracies and lapses in daily Purpose T assessments can result in an avoidable pressure sore
Emergency Department	Fall with harm	Appropriate falls risk assessments must be completed to reduce the risk of falls
Pantomime Ward	Pressure sore – July 2021, open and closure form submitted November 2021)	Device related pressure ulcer; to ensure that any unfamiliar devices are reviewed and risk assessed for pressure related issues, improve documentation and care planning when a device in place
Mason Ward	Pressure sore – July 2021, open and closure form submitted November 2021)	Increased observation for patients with devices fitted to reduce risk of developing pressure ulcer; medical plan required for removal and management of devices, improve the documentation of weight and nutritional status

Wrexham Maelor Hospital – Midwifery and Women's Services (2)

Location	Incident	Immediate Learning
Labour Ward	ITU admission post-delivery due to intracranial haemorrhage	Importance of full examination including fundoscopy

			The importance of following the appropriate management of hypertension as per pre-eclampsia policy
Labour Ward	Never Event: retained swab following delivery – identified in primary care	RAPID LEARNING PANEL <ul style="list-style-type: none"> Assurance that locums aware of local practice required. Use of second checker - 2 Health Care Professionals must document that instruments and swabs count Impartial Investigation Officer (IO) identified 	Documentation of swab and instrument counts needs to be completed by two health professionals and signed by both. This has been communicated to staff by email, at handover and safety briefings Local governance teams to audit to ensure compliance

Central Area – community hospital (1)

Location	Incident	Immediate Learning
Ruthin Community Hospital – Menlli Ward	Pressure sore ungradeable (reported June 2021, open and closure form submitted November 2021)	Importance of regular checking of all areas – particularly ears when patient on long term oxygen via tubing.

West Area – community hospital (1)

Location	Incident	Immediate Learning
Ysbyty Dolgellau, Cader Ward	Pressure sore Grade 3 (reported August 2021, open and closure form submitted November 2021)	Gaps in intentional rounding caused by staffing issues can result in avoidable pressure sores for patients

Ty Llewelyn, MSU (MHL D) (1)

Location	Incident	Immediate Learning
Branwen Ward	<p>Patient found deceased in bed</p> <p>RAPID LEARNING PANEL</p> <ul style="list-style-type: none"> • Medically deteriorating patient should be managed according to policy and National Early Warning Score (NEWS score) with appropriate escalation with a Mental Health setting • Immediate refresher training re NEWS score and triggers for repeat observations and escalation • Remind staff of expectations in relation to therapeutic observations • Immediate review of handover procedure on ward • Address immediate workforce issues • External investigating officer identified 	<p>Patients in psychiatric settings, who require medical input, should be subject to the same protocol as in an acute setting and staff adhere to the observation policy (physiological observations) and escalate according to NEWS Score.</p> <p>Training & education of staff in relation to NEWS (National Early Warning Score) and escalation was provided immediately following this incident as well as reiterating the importance of, handover procedures between staff.</p> <p>Independent (external) investigation commissioned.</p>

Ysbyty Glan Clwyd – Acute (3)

Location	Incident	Immediate Learning
Radiology	Unreported potential malignant lesion from 2008	To consider renal ultrasound of contrast CT should appearance of lesion be for further investigation
Surgical Assessment Unit	Fall with harm	Appropriate t risk and observation assessment for patients with catheter must be completed to reduce risk of fall and catheter care (patient was in a cubicle, medical condition detailed confusion and appeared to trip over catheter bag).
Ward 5	Fall with harm	Patient had a seizure which was felt to have resulted in fall; observations increased.(Subsequent investigation confirmed not a reportable incident)

Ysbyty Gwynedd – Acute (5)

Location	Incident		Immediate Learning
Ogwen Ward	Lack of response to deteriorating physiological observations	RAPID LEARNING PANEL <ul style="list-style-type: none"> • Nurse must escalate to registrar when no response from SHO • Possible overburden from bleeps • Accuracy of recording NEWS score to ensure correct escalation for deteriorating patient • AIT training organised for orthopaedic team and 	Ensure escalation of deteriorating patient and accurate Failure to physiological observations (NEWS) and response

		AIT will be based on the ward to support training	
Anaesthetics	Epidural inserted for failure to progress during labour. Patient went into respiratory arrest.	RAPID LEARNING PANEL <ul style="list-style-type: none"> • Test dose not given • Distraction contributed to incident • Immediate learning shared on test doses • Impartial IO identified 	The importance of volume of test dose when administering epidural Communication circulated across Health Board
Ophthalmology Department (eye clinic)	Lost to follow up; vision loss		Improve communication and administration; undergoing further investigation
Ophthalmology Department (optician/optometrist)	Delay in follow up; vision loss		Improve communication and administration; undergoing further investigation
Emergency Department	Delay in diagnosis and management of an ischaemic limb. Patient underwent leg amputation	RAPID LEARNING PANEL <ul style="list-style-type: none"> • Delays at each step of process contributed to overall delay • Internal safety alert circulated on identification of acute vascular injury 	Diagnosis can be made on clinical presentation and history i.e. without CT angiogram, to prevent delay in transfer to Ysbty Glan Clwyd (YGC)

		<ul style="list-style-type: none"> Impartial IO identified, external vascular opinion requested (not identified) 	
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Ysbyty Abergele (3)

Location	Incident		Immediate Learning
Eye theatre	Never Event: Trocars left in eye	RAPID LEARNING PANEL <ul style="list-style-type: none"> Lack of formal checklist, counting in and out not routinely used Integrated pathway documentation to be shared immediately Impartial IO requested 	<p>To ensure there is formal counting documentation is included with the integrated care pathway documentation</p> <p>Environment, distractions, staffing, have been highlighted as contributory factors in this incident.</p> <p>White boards now used to aid check in check out</p>
Orthopaedic theatre	Never Event: A 32 mm head and 36 mm liner were used from a primary hip procedure		<p>Templating prior to surgery will offer preparedness for the surgical team with regards to size of liner/heads to be used</p> <p>Review of Local Safety Standards for Invasive Procedures (LocSSIPs) to ensure the size of implants included</p> <p>White boards to be utilised.</p>
Ophthalmology Department	Lost to follow up resulting in vision loss		<p>Severe issues with demand and capacity for the Intravitreal Injection (IVT) service; the service is on the risk register and actions to reduce waiting times are being reviewed including training and funding via a Business Case</p>

District Nursing (3)

Location	Incident	Immediate Learning
Deeside Locality	Pressure ulcer – unstageable/unclassified (reported July 2021, open and closure form submitted November 2021)	Failure to provide upgraded pressure relieving equipment. Communication issues with independent living facility.
Buckley Health Centre	Pressure sore Grade 3 (reported July 2021, open and closure form submitted November 2021)	Omissions in nursing documentation; failure to provide correct pressure relieving equipment.
Conwy West Locality	Pressure sore Grade 3 (reported June 2021, open and closure form submitted November 2021)	Patient discharged in error resulting in period of 4 months without input from district nursing; lack of appropriate pressure relieving equipment in place and lack of risk assessments.

North Wales Adolescent Service – Abergele Hospital (1)

Location	Incident	Immediate Learning
Kestrel Ward	Alleged abuse (inappropriate force) by staff on patient	<p>All agency staff must have undertaken BCUHB approved RPI training Staff members should undertake full debrief inclusive of post RPI enquiries relating to physical health</p> <p>All allegations shared with Safeguarding and child protection referral sent; police informed. Agency staff removed from further shifts until investigation undertaken</p>

Themes identified - Nationally reported incidents

Acute vascular injury - Two nationally reportable incidents reported by Emergency Departments (Ysbyty Glan Clwyd and Wrexham Maelor Hospital) have both occurred as a result of delays in transfer to the vascular service. Both patients underwent amputation of their leg. An internal safety alert has been circulated in relation to the importance of early identification of an ischaemic limb. Confirmation has been received from the Clinical Lead of vascular services that patients are accepted based on history, presentation and findings from clinical examination that indicate acute ischaemic event. A patient that meets these criteria must be transferred and admitted to YGC vascular service and imaging completed on arrival. Discussions are underway with Welsh Ambulance Service Trust in relation to urgent transfers.

Inadequate observations (NEWS score) - Two nationally reportable incidents occurred that relate to the incorrect calculation or action of NEWS score, leading to incorrect frequency of observations and subsequent delay in escalation. One in an acute side Ysbyty Gwynedd (YG) and one in a Mental Health setting (Ty Llewellyn). In both cases there were errors in NEWS score calculation leading to delays in escalation. In both cases, immediate steps were put in place to provide refresher training for all clinical staff on the ward.

Other reviews of significance

Review of cluster incidents - patients undergoing Laparotomy Ysbyty Glan Clywd

Three cases were identified and reviewed by a multi-disciplinary panel led by the Interim Deputy Medical Director, one of which there were no care and delivery issues identified.

Of the other two, findings include:

- Questions were raised around the initial choice of radiology review as opposed to a Computerised Tomography (CT) scan based on this gentleman's presentation and past medical history
- Delays were noted in the reaction to further CT intervention as the patient failed to progress.
- The lack of nutritional intervention was raised as a concern.
- Lack of evidence around Multi Disciplinary Team discussions and ceiling of care documentation are noted prior to considering a return to theatre.
- Delay in reaction to appropriate intervention following the Day 7 CT findings as the patient fails to progress post operatively.
- Concerns that timely, repeat and appropriate interventions were not undertaken as the patient is not improving

Immediate recommended actions from the review to include:

- Learning from these specific incidents to be shared immediately.
- Immediate discussions to take place with the surgical teams.
- CT facilities are available within YGC however, radiology is sometimes chosen; its rationale needs to be understood. CT could potentially have changed the course of initial treatment on admission.
- Nutritional element requires immediate review. Existing arrangements not fit for purpose. Consultant to be identified to oversee the nutritional team to ensure that patients are optimised prior to radical surgery.
- Ceiling of care discussions to take place when appropriate and fully documented.
- MDT discussions to take place to involve the whole team when making decisions around patient care.
- A BCNUB learning exercise for general surgery to be led by Medical Director YGC around procedures for urgent laparotomy cases.
- Networking within specialty groups' cross-site is suggested to provide clinical expertise/advice/support.

Transfers between sites and their timings to remain based on patient's best interest decisions

Ophthalmology Incidents- Ysbyty Gwynedd and Ysbyty Glan Clwyd.

The Associate Director of Quality Assurance requested a review into the number of ophthalmic incidents being reported to the Delivery Unit (DU). This request followed a query from the Delivery Unit that BCNUB were reporting less ophthalmic incidents than other Health Boards within Wales. The Acting Assistant Director of Clinical Governance was

asked to undertake a review on ophthalmology incident reporting since reporting resumed on 14th June 2021.

Two incidents were identified as incidents where there was a high probability that harm had been caused through inaction and therefore will be retrospectively reported to the Delivery Unit.

Advice from Legal and Risk, is that these cases will be outside of PTR (over £25,000) and will become clinical negligence claims.

Independent external investigations ongoing

There are currently three independent external investigations ongoing as commissioned by the Health Board:

Location	Incident	Update
Ty Llewelyn MHL D	Issues regarding monitoring a patient with deteriorating medical condition who subsequently found deceased	The external independent investigation is currently ongoing. The final report is expected in January 2022.
CMHT (East) MHL D	Patient known to community mental health team arrested on suspicion of murder.	Independent investigation ongoing. There has been some delay as the initial external investigation officer identified subsequently declined meaning a further review team had to be identified.
Hergest Unit MHL D	In patient suicide	Report has been received from the independent reviewers. MHL D are currently reviewing the recommendations and developing an action plan. The division are meeting with the family in late December 2021.

To note- The Patient Safety Team is currently taking steps to identify a suitable vascular surgeon from outside of the organisation to offer an impartial in regards to the two Vascular Incidents listed in the table “ National reported Incidents”

LEARNING FROM INCIDENT LEARNING PANELS

Incident Learning Panels (ILP) were introduced as part of the new Incident Policy. 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 ILP. There has been an initial focus on quality of reports by the panel and services have taken on feedback provided with a subsequent marked improvement noted.

Plans are in place to begin extracting and sharing learning from the Incident Learning Panel to include:

- Learning on a page to replace the “lessons learned “template, re-named **Insight**
- Monthly ILP Bulletin
- Mandated Learning Event following each completed investigation

During the months of October and November 2021, 82 investigation reports were presented to the ILP. Initially 51 were Green approved by the panel, 14 were Amber deferred (minor changes needed) and 10 classed as Red deferred (fundamental changes needed).

Data indicates that there is an improvement in approval rates of investigation reports since the beginning of November 2021 with an increase in Green approved and Amber approved reports coming to the ILP. This can be attributed to the support provided by the Patient Safety Team also with the introduction of the Investigating Officer clinics and greater clarity around the expectations of the Incident Learning Panel and the report style/template.

Information on learning from Never Events is included in the next section.

Avoidable Grade 3, 4 unstageable pressure ulcers

There were 10 investigation reports approved at ILP relating to reportable, avoidable pressure ulcers. Themes and trends have been identified, which are as follows:

- No evidence of increasing intentional rounding as/when required.
- A delay in completing documentation on admission i.e. pressure ulcer management plans and Purpose T documentation.
- Lack of communication with the Orthopaedic department regarding management plans/documentation for patients with orthopaedic devices i.e. fixation braces.
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

This information has been fed back to Tissue Viability Nursing colleagues who are invited to be part of the ILP. It is intended that pressure ulcer prevention and care will become a priority project as part of the new Patient Safety Programme being developed by the Quality Department and Transformation and Improvement Department.

Falls

During the months of October/November, 17 Falls Investigation reports were approved following a review at the Incident Learning Panel.

Themes and trends have been identified as:

- Lack of timely and fully completed risk assessments which may have identified a requirement for greater enhanced observation.
- A lack of completed bed rails risk assessments.
- Failure to ensure correct non-slip footwear is in place.
- Call bell not utilised or not to hand.

- Lack of updated risk assessments following a change to a patient's clinical presentation.
- Lack of communication during patient handover.

The new Chair of the Inpatients Falls Strategic Steering is Mandy Jones, Interim Deputy Executive Director of Nursing. A summary of action by the group includes:

- The revised Policy NU06 Prevention and Management of Inpatient Falls to be resubmitted Chair of QSE following amendments
- E learning package is with NWISS, awaiting confirmation that is it live on ESR for BCU Staff to access level 1 a for all staff and level 1 b Completion of the Falls & Bone Health Multifactorial Assessment for all adult In patient falls.
- Data analysis and dashboard development in progress with informatics.
- Health and Safety Executive (HSE) visit took place 16th November to review progress against HSE notice

The Chair of the Inpatient Falls Steering Group plans a review and refresh of the terms of reference (TOR), membership and improvement/action plans during December to ensure fit for purpose and the group for inpatient fall will combine with the Community Falls Steering group as one overarching health board group.

It is intended that falls prevention will become a priority project as part of the new Patient Safety Programme being developed by the Quality Department and Transformation and Improvement Department.

NEVER EVENTS

During the reporting period, there were three Never Events reported

- Retained object following surgery.

Learning: Environment, distractions, staffing have been highlighted as contributory factors, and no formal counting documentation in place for this type of surgery. Immediate measures have been put in place in terms of standardising processes and practice in theatres. A full investigation is underway.

- Retained Swab following birth

Learning: Documentation of swab and instrument counts needs to be completed by two health professionals and signed by both. This has been communicated to staff by email, at handover and safety briefings. A full investigation is underway.

- Wrong Implant (Datix raised in August, confirmed Never Event and subsequently reported following further investigation)

Learning: ensure checks for implant compatibility are in place. Any member of MDT should feel empowered to speak out in interests of patient safety. A full investigation is underway.

The mindful use of the WHO checklist features as a contributory factor with all three never events. There are work streams under development to address this including commissioning of external human factors expertise to support a renewed piece of work on surgical safety commencing in January 2022.

An *All Wales Never Events: Invasive procedures and human factors Symposium* was held recently with attendees and representation from the Health Board. Learning from this event is being shared.

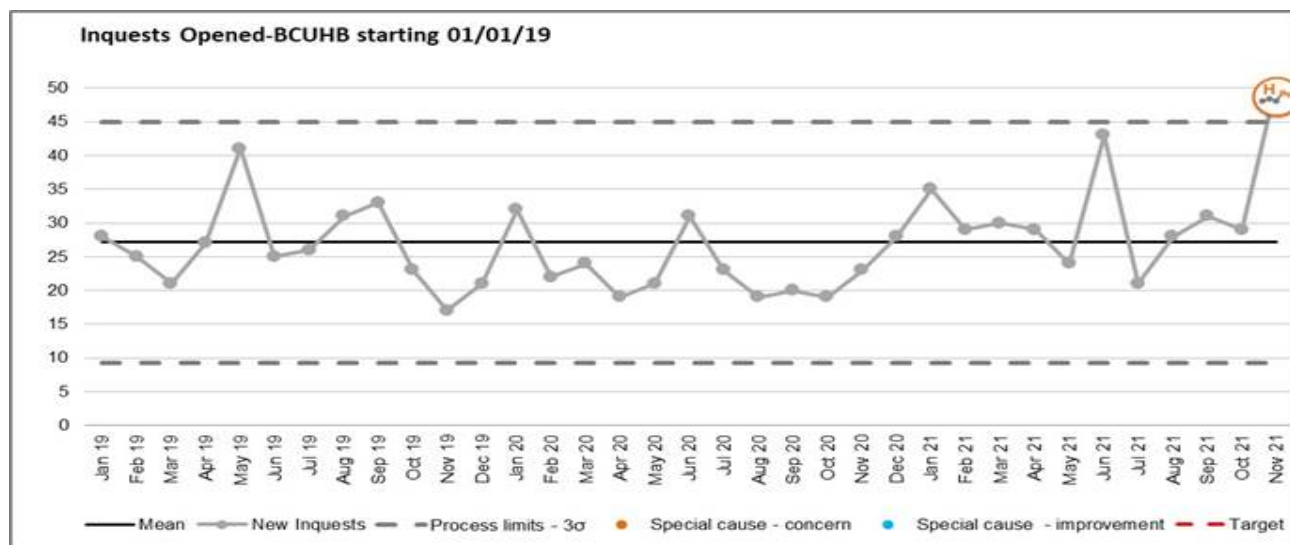
In total eight Never Events have been reported so far in 2021/22 (compared to five in 2020/21 and six in the full year of 2019/20).

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)

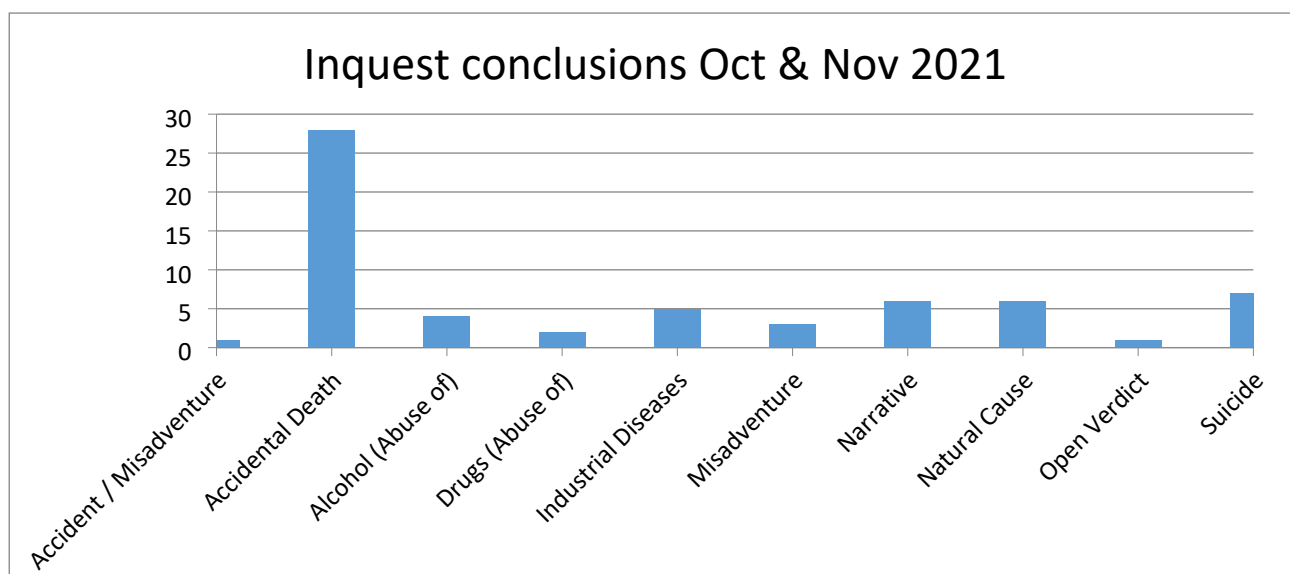
HM Coroner notifies the Health Board when they have opened an inquest into the death of a patient and they require further information from the Health Board.

During the relevant time period. October and November 2021, **81** inquests or requests for information from the Coroner were opened, with 52 of these received in November.



When looking back at previous months and comparing the data, since the commencement of the new Coroner in the North Wales West region (December 2020), there has been an increase in the number of inquest opened in this region, bringing the numbers in line with those for East and Central.

63 inquests were concluded between 1st October and 30th November 2021, with the inquest conclusions shown below.



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 Prevention of Future Deaths (PFD's) response timescales are monitored and shared with the relevant clinical and managerial leads. During this time period, two Regulation 28 Prevention of Future Deaths (PFDs) were issued by HM Coroner to the Health Board. The underlying theme for both of these was a failure of the Health Board to meet its own targets, and failure to act in a timely manner. The response to both of these Regulation 28 reports are in progress.

As part of an inquest, the difficulties with ERCP provision, both at YGC and the wider Heath Board, were discussed. The Medical Director for Central Acute was summonsed to give evidence, and whilst verbal assurance of the recruitment process and the 'plan B' should no suitably qualified clinicians apply was given, the Coroner requested confirmation of this by 10th December 2021.

During the period for this report, there is evidence of an increasing workload, and the Inquest Team has continued to provide support to services which has received positive feedback

More recently, the lead managers for inquests and patient safety have strengthened the collaboration between the teams, ensuring escalation and prioritisation of incidents linked with inquests, to enable a more proactive approach to actions plans and the provision of evidence in advance of the inquest being listed.

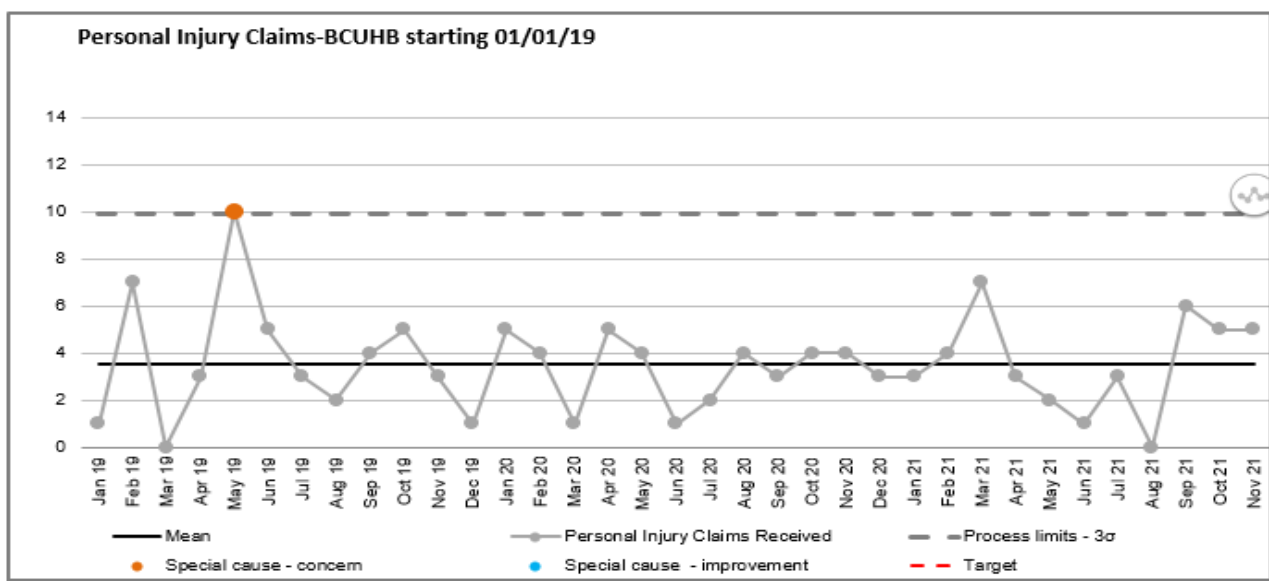
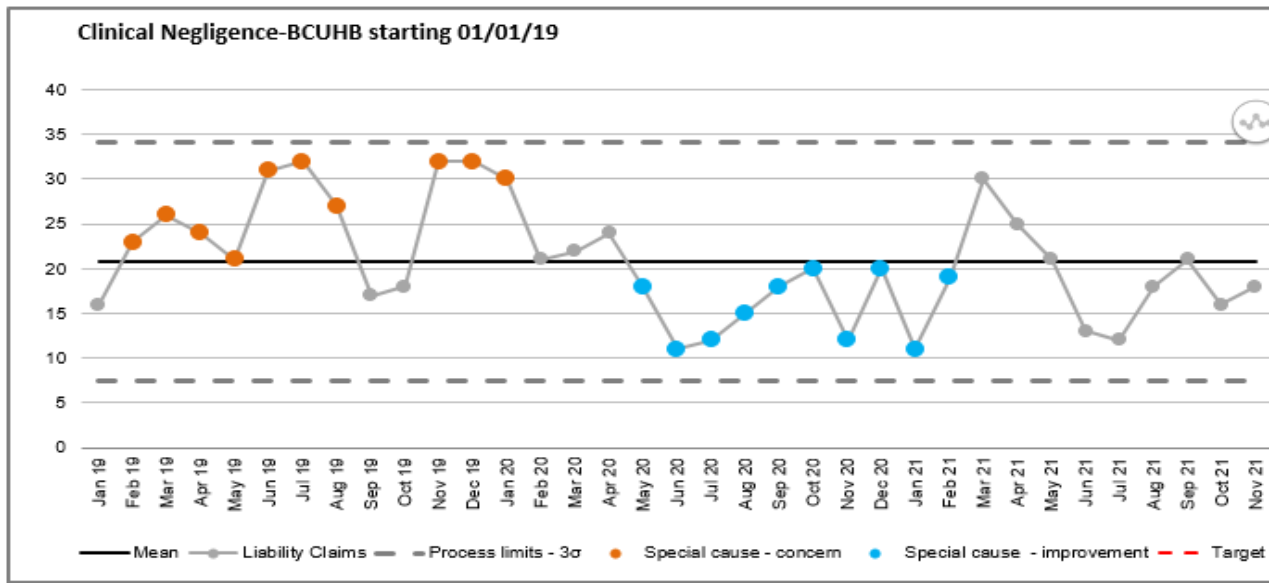
Additional temporary resource has been secured to ensure evidence against historical action plans is in place, to avoid future issues identified above.

LITIGATION

During the relevant time period, 44 claims or potential claims were received against the Health Board. Of these, 34 related to clinical negligence and 10 related to personal injury.

When looking back at previous months and comparing the data, following the start of the Covid-19 pandemic and when Services started to return to a new normal it was anticipated

that the Health Board would see a further rise in claims. The number of new claims have fluctuated; however, they are starting to rise again as expected.



Significant claims and learning

During the relevant period, 54 claims were closed. Of these, 43 related to clinical negligence and 11 related to personal injury.

The total costs for these closed clinical negligence claims amounted to £5,490,369.67 and £114,152.61 for Personal Injury Claims before reimbursement from the Welsh Risk Pool. The most significant claims and related learning are detailed below:

- i. *Failure to diagnose slipped upper left femoral epiphysis from x-ray in July 2013 and the subsequent delay in appropriate treatment (£1,515,985.91)*

Learning

Any trends or recurring problems are identified and appropriate action put in place. Amongst the recurring themes from the local discrepancy meeting are increased radiology workload and interruptions whilst reporting.

As part of the YGC redevelopment, there was an opportunity to redesign part of the department and as part of this process, the reporting rooms have been designed to be less accessible to persons outside of Radiology, which in turn will result in fewer interruptions.

The Peer Review Process has been introduced to help ensure consistency in reporting. These are used as learning opportunities and the results are shared within radiology via regular meetings.

ii. Delay in diagnosing fractured hip resulting in delay of surgery (£69,085.69)

Learning

Escalation procedures are in place to ensure Senior Operational Managers attend ED during times where patients arriving by ambulance and are unable to be admitted into the department. A process of escalation was introduced in ED towards the end of 2015.

Board rounds are being utilised to ensure patients' needs are addressed and communications have been sent to staff from the Head of Nursing to remind of the importance of good verbal & written communication. In addition to concerns being written in notes, the MDT hand overs will allow for follow up of any concerns about patients.

A safety brief discussing falls risk is now embedded in practice. Staff also have pocket reminders regarding best practice relating to falls for ease of reference.

iii. A failure to refer the Claimant for a MRI scan after first consultation, in order to rule out the presence of an acoustic neuroma. (£3,009,771.46)

Learning

Training for ENT and Audiology staff in the presentation and investigations of acoustic neuromas and other neurological pathology.

New Balance clinic was introduced in 2015 to focus clinical expertise on dizziness cases.

For unilateral tinnitus and hearing loss cases, Audiology department protocols have been updated to allow staff to request MRI IAMS themselves to combat any delay.

iv. Failure to obtain informed consent for TVT procedure and failing to mention conservative options or alternative operative interventions (£93,584.80)

All medical staff are required to reflect upon any clinical incidents they are involved in at their annual appraisal.

This incident was shared at the Women's Quality, Safety & Experience Sub-group in January 2021 to ensure shared learning across North Wales. Procedure specific consent forms have also been developed and implemented.

- v. *Failure to detect/diagnose/treat claimant's ectopic pregnancy in July 2017 following two attendances in hospital. (£35,700.50)*

Learning

Case was presented at the Gynaecology Mortality and Morbidity and audit meeting to highlight learning points.

Educational sessions to be delivered for medical and EGU nursing staff by Gynaecology Lead Consultant to increase knowledge and awareness.

Learning points from case to be included in *Sharing Learning from a Significant Clinical Incident Bulletin* and shared with all staff within Gynaecology BCU and at the North Wales Gynaecology Forum (NWGF).

Women's Division have been successful in a bid for procurement of a Ultrasound scan machine specifically for the Emergency Gynaecology Unit. Two consultant scanning sessions to be dedicated each week. This addition to the service will support timely patient assessment, case management and opportunity for shared learning between sonographers and Gynaecologists.

- vi. *Failure to undertake required risk assessment prior to fall (£34,236.79)*

Learning

Ward nurses, physiotherapists and occupational therapists are now working together in order to improve collaborative and joint assessment, patient care planning and care giving. This is being implemented across other community hospital sites and will provide assurances that communication between the services is robust and will enhance patient safety.

Details of manual handling needs are now displayed in picture form on magnetic white boards situated at the patient's bedsides and are updated by the Physiotherapists according to patient needs.

Additionally, Safety Briefs are held on the Ward. This is a system where relevant information which could include information regarding patient handling needs is discussed with ward staff. This ensures appropriate information is communicated and discussed.

- vii. *Failure to recognise chronic infection in the right knee joint and failure to perform a deep tissue biopsy (£310,277.72)*

Learning

The case has been presented at an Audit Meeting within the department to share this matter and the actions taken by the surgeon to raise awareness of cases of this kind. A presentation of learning in this matter also focused on Orthopaedic SSI surveillance.

viii. Unacceptable practice to inject a steroid into the knee following the arthroscopic procedure as this increases the risk of infection (£82,417.64)

Learning

All knee surgeons in the department no longer use intra-articular cortisone during knee arthroscopies. It is a practice that has stopped.

ix. Failure to diagnose vertebral artery dissection (£65,476)

Learning

Annual Call and notes audits are undertaken to ensure all who are triaging in GPOOH maintain a good clinical competence.

Training for new Nurse Practitioners and Urgent Care Practitioners is an 8-week induction to ensure assessment of triage, clinical examination and records keeping of assessments is adequate and monitored by trained mentors. The practitioner is unable to practice independently until signed off by an experienced clinician.

Educational evenings will be held including staff communications where lessons can be discussed and shared.

A SOP has been created to provide both ED and Out of Hours with the process of referring patients safely between departments.

x. Failure to treat a fractured clavicle appropriately (£53,229.50)

Learning

The learning from this case was presented to the Audit Meeting and the department, discussing the issues to raise awareness and share learning widely.

Fractured clavicle leaflets are in place to give to patients with information informing them what to expect from their injury.

With regards to clinical negligence, the Health Board has seen a rise in claims from North Wales Community Dental, particularly in the East area. These claims are likely linked to emergency dental work following fall out from appointments cancelled /unavailable due to Covid19. This will continue to be monitored.

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

Themes identified from personal injury claims

A continued rise in the numbers of claims relating slips and trips.

Other categories remain steady and we continue to see claims being brought for the breaches of Data Protection.

Personal Injury claims savings due to discontinued or favourable settlements for this period were £51,177.28.

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. Welsh Government have now confirmed that additional contributions will be required. BCUHB's share of the increase will be 17.07% and an additional cost of £2.35m in addition to the contribution already made, creating a significant impact on the overall financial position.

The Claims Team have experienced some issues with the return of documentation and/or evidence from the Workforce, Organisation and Development Department and some nursing areas. Through escalation processes, however these have been rectified.

CONCLUSIONS AND RECOMMENDATIONS

This report provides the Quality, Safety and Experience Committee with information and analysis on Nationally Reportable incidents and Never Events occurring in the last two months.

The QSE Committee is asked to note the report.

The QSE Committee is also asked to be aware of

- the likely significant harm caused to the two patients where there has been a delay in treatment for acute vascular injury.
- the likely significant harm caused to a yet to be confirmed number of ophthalmology patients waiting to be seen.
- the early development of the new Patient Safety Programme and commissioning of external human factors expertise to support surgical safety work.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee 11 th January 2021						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Quality Awards, Achievements and Recognition						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris Executive Director of Nursing and Midwifery/Deputy Chief Executive						
Awdur yr Adroddiad Report Author:	Julie Ward-Jones, Head of Quality Assurance						
Craffu blaenorol: Prior Scrutiny:	Carolyn Owen, Interim Assistant Director Patient Safety & Experience Mathew Joyes, Associate Director Quality Assurance						
Atodiadau Appendices:	None.						
Argymhelliad / Recommendation:							
The Committee is asked to note this report.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	√
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>This paper provides an outline of quality related awards, achievements and recognitions for the period October and December 2021. It is important to note that the COVID-19 pandemic has had a significant impact in this area, with the focus rightly being on service delivery and services changes in response to the pandemic, and many award and recognition schemes were deferred or cancelled.</p>							
Cefndir / Background:							
<p>During the last two months, a number of staff, services and initiatives have received a quality related award, achievement or recognition, a summary of which is below:</p> <p>Vascular staff receive 'special' gift after saving 50-year love affair: An intricate and clever sculpture delivered to each of two vascular service staff signified more than just saving a life for a couple who had been married for 50 years. The patients of Ysbyty Glan Clwyd's vascular department sent the unusual and personal gift to the team members after a lifesaving operation in July this year. Called "Swan Lake" the hand carved pieces were a thank you from the 82 year-old patient for not only repairing the most life-threatening kind of aneurysm but for giving him the chance to rekindle his love of woodworking.</p>							

The patient was also quick to thank the surgical team and all the staff supporting the vascular hub at Ysbyty Glan Clwyd.

Patient thanks new Syncope Clinic at Wrexham Maelor Hospital for 'amazing care': A patient has praised the new Rapid Access Syncope Service at Wrexham Maelor Hospital, which has reduced appointment waiting times for people who suffer from blackouts from 12 to four weeks. Syncope or transient loss of consciousness (T-LOC), more commonly described as a blackout, affects approximately 42% of the population at some point during their lives. Syncope is commonly due to undetected heart conditions causing cardiac arrest and sudden death. The service, the first to offer a dedicated Rapid Access Syncope Clinic in North Wales, opened the weekly clinic for face-to-face referrals in August 2020 and has reduced the appointment waiting times for patients by 66%. The service was set-up in response to the 2019 European Society of Cardiology (ESC) guidelines which advised that patients presenting with T-LOC at GPs and Emergency Departments to be rapidly referred to specialist syncope clinics.

Two decades of Filipino smiles, resilience and dedication recognised by critical care colleagues: Critical care colleagues have paid homage to 20 years of service from a group of “honorary Welsh” nurses who left their families almost 10,000 miles behind to save North Walian lives. Staff from Ysbyty Glan Clwyd’s Intensive Therapy Unit gathered last week to celebrate Filipino colleagues who came to North Wales in 2001. They came as part of a recruitment drive by the then health board, which saw 18 Filipino nurses arrive at Ysbyty Glan Clwyd in August of that year – one of three tranches to arrive from the Philippines two decades ago.

Family praise life-saving staff on Ysbyty Gwynedd Intensive Care Unit: The family of a woman who spent six months in Ysbyty Gwynedd battling COVID-19 have praised the staff on the Intensive Care Unit (ICU) for saving her life. Staff clapped and cheered as Donna Jones, 43, was reunited with her family after leaving hospital earlier this month. Donna became seriously unwell with COVID-19 in March 2021. She spent five months on the Intensive Care Unit and during that time was in an induced coma and placed on a ventilator. Donna continued to receive treatment on ICU and over the next few months that included physiotherapy sessions to help her regain her strength. To thank you the team on ICU and the staff on Moelwyn Ward, who cared for Donna during her final weeks in hospital, Donna’s family have raised funds and delivered gifts for the staff.

Wrexham Maelor renal patient hopes to help others with new book: A patient receiving dialysis at Wrexham Maelor Hospital has published a book called Transplants and Fears about his experiences in the hope to help other people going through a similar journey. Chris Simpson was introduced to Outside In, a group at Glyndwr University, by his social worker Caron, and was encouraged by the group to turn his writings into a book.



Seven teams in North and West Wales win £400,000 funding to improve cancer services: The Moondance Cancer Initiative has awarded just over £400,000 to seven innovative projects across north and west Wales to improve cancer services. The Moondance Cancer Initiative Innovation Time

Awards were created in Summer 2021 to encourage and support staff across Welsh health and care

services to adopt practical and clinical innovations to improve cancer outcomes with immediate impact - whether in cancer services, diagnostics, treatments, enabling technologies or workforce on the ground. Teams in Betsi Cadwaladr Health Board have been awarded just over £200,000 to:

- Introduce a dedicated new pathway for cancers which are especially difficult to diagnose ('malignancies of unknown origin'), linking to the planned rapid diagnosis centre
- Introduce a new endoscopy list that will enable faster diagnosis (and therefore faster progress into treatment) for patients who need some sedation to tolerate endoscopy procedures
- Encourage more people to engage with bowel screening at home
- Trial the use of an AI solution to support pathology teams in the diagnosis breast cancer, enabling more rapid diagnosis in time.

North Wales NHS team scoop top national award for life-changing support of teen with complex needs: A North Wales healthcare team have scooped a top national award for going 'above and beyond' to enhance the quality of life of a teenager with complex needs. Staff from Foelas Ward at Bryn y Neuadd Hospital, Llanfairfechan, and the Renal Home Therapy Team, based at Ysbyty Gwynedd, were recently crowned the Nursing Times' Learning Disabilities Nursing award winner at a glittering awards ceremony in London. The forward thinking healthcare professionals were recognised for their pioneering work to support a teenager who has complex learning disabilities and kidney disease. The judging panel, made up of leaders from the nursing and wider healthcare sector, praised the team's 'inspirational, collaborative leadership'.

Doctors recognised for their dedication to research: Doctors across the Health Board have been recognised for their dedication to research with a special award. The Oncology Consultants at Ysbyty Gwynedd, Consultant Haematologist Dr Earnest Heartin at Glan Clwyd Hospital and Wrexham Maelor's Consultant Physician Dr Orod Osanlou were all winners of the Principal Investigator Commitment to Research Award at this year's Betsi Cadwaladr University Health Board's Research & Innovation Awards. Director of Health and Care Research Wales, Professor Kieran Walshe, said: "We want to congratulate the winners and thank all our research staff who have worked tirelessly throughout the pandemic to continue essential research work. We are proud of the efforts staff have made to continue providing world-class care to patients in all disease areas."



Wrexham doctor invents medical breakthrough for the NHS: A Wrexham doctor has joined forces with a medical supplier to launch a ground-breaking new aid which could vastly improve the lives of up to 90,000 NHS patients across the country. Drawing on his many years in the clinical field, Dr Robert Lister, a dermatologist at Wrexham Maelor Hospital, recognised a worrying trend amongst patients failing to wear the compression devices needed to manage vascular conditions and chronic oedema. Talking to patients, many elderly, he found that a big issue was that the compressive nature of the standard one-piece garments supplied made them very difficult to put on or take off, especially for those who struggled to bend down or had dexterity issues. In response, Dr Lister decided to take matters into his own hands by inventing a two-piece system which can be more simply manoeuvred over a patient's foot, thereby making application and removal much easier. Four years later, and the end result - the patented duomed soft® 2easy product – has

been developed and fast-tracked to market by local medical supplier, medi UK and received NHS backing.



North Wales nurse recognised with one of the profession's top accolades:

Nia Boughton, a Consultant Nurse for Primary Care with Betsi Cadwaladr University Health Board, was named the winner of the Royal College of Nursing Wales' Advanced & Specialist Practice award. The profession's top accolades celebrate innovation, skill and dedication in nursing across 15 categories, with winners chosen from more than 500 entries. Nia,

who has worked in the profession for over 20 years, was recognised for her work to improve the quality and consistency of training provided to nurses working in primary care settings across North Wales. This includes introducing an innovative training framework based on a social model of care – which examines the range of factors that contribute to a person's health, rather than just their medical presentation. Practitioners using Nia's framework have reported a significant improvement in their training experience, while an initial evaluation suggests it has improved patient outcomes and led to greater consistency in the quality of consultations carried out by Advanced Nurse Practitioners.



Orthopaedic Surgeons nationally recognised for sustainable healthcare project:

Mr Prash Jesudason from Ysbyty Gwynedd and Mr Preetham Kodumuri from Wrexham Maelor Hospital were one of five surgical teams competing in the first ever 'Green Surgery Challenge', co-hosted by the Royal College of Surgeons and the Centre for Sustainable

Healthcare. The NHS accounts for four per cent of the UK's carbon footprint with operating theatres having a particularly high-energy use. For their challenge, they focused on hand surgery, reducing the consumables used and the volume of clinical waste generated by creating a new, streamlined procedure pack. The team also reduced the use of ward beds and theatre space, effectively challenging the assumption that all surgical procedures must take place in theatres, when minor surgery can be carried out in rooms with lower energy requirements. The project, which was joint runners up in the challenge, was also supported by team members from both hospital sites which include Iona Williamson, Sterile Services Manager, Teresa Revell, Deputy Team Leader Day Case Unit, Shan Roberts, Theatre Practitioner and Jack Houghton, Speciality Doctor in Orthopaedics.



Wrexham Maelor Hospital awarded for commitment to patient safety by the National Joint Registry:

Wrexham Maelor Hospital has been awarded a 'Quality Data Provider' certificate by the National Joint Registry (NJR), after successfully completing a national programme of local data

audits and meeting a number of targets related to patient safety. The NJR monitors the performance of hip, knee, ankle, elbow and shoulder joint replacement operations to improve clinical outcomes primarily for the benefit of patients, but also to support orthopaedic clinicians and industry manufacturers. Trauma and Orthopaedics Consultant Ian Starks, from Wrexham Maelor Hospital,

said: “We're delighted to receive this certificate, improving patient safety is very important to us, and whilst the ‘NJR Quality Data Provider’ certificate recognises the hard work of our department in meeting the NJR requirements, special thanks must go to Alice Eyre for all the hard work she has put into the data collection and processing.” National Joint Registry Medical Director, Mr Tim Wilton, said: “Congratulations to colleagues at Wrexham Maelor Hospital. The Quality Data Provider Award demonstrates the high standards being met towards ensuring compliance with the NJR and is often a reflection of strong departmental efforts to achieve such status.

Holyhead doctor named Wales GP Trainee of the Year: A Holyhead doctor who has a passion for rural medicine has been named GP Trainee of the Year at this year's Royal College of General Practitioners (RCGP) Awards. Dr Laura Bennett, who is one of three new GPs at Hwb Iechyd Cybi in Holyhead, received the award after achieving the highest score across her exams in Wales. Dr Bennett, who joined the Holyhead surgery in her first role since qualifying in August 2021, picked up her prize in a glittering ceremony in Cardiff earlier this month, where the Chair of the RCGP, Professor Amanda Howe, presented her with the award.



BCUHB Consultant first in the UK to use Artificial Intelligence to improve prostate cancer diagnosis: Dr Muhammad Aslam, a consultant pathologist and clinical director of North Wales managed clinical support services at Betsi Cadwaladr UHB, is in the vanguard of improving the quality and speed of prostate cancer diagnosis. He and four consultant colleagues have been using the Galen platform from medical analytics firm Ibex to check digital slides taken from biopsies on suspected prostate cancer patients. It's the first artificial intelligence application cleared for clinical usage in histopathology in the UK.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	HIW Inspection of the Hergest Unit						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance						
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Atodiadau Appendices:	HIW Inspection Report						
Argymhelliad / Recommendation:							
The Committee is asked to receive the HIW report and subsequent action plan.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	√	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>Healthcare Inspectorate Wales (HIW) recently completed two unannounced mental health inspections of the Hergest Unit. The first starting the evening of 6 September 2021, the second starting the evening of 20 September . The following wards were visited during these inspections:</p> <ul style="list-style-type: none"> • Aneurin - Female acute mental health admission ward • Cynan - Male acute mental health admission ward • Taliesin - Psychiatric Intensive Care Unit (PICU) <p>The HIW team for the inspection comprised of two HIW inspectors and two clinical peer reviewers. A HIW inspection manager led the inspection. The first unannounced visit took place on the evening of Monday 6 September 2021. Shortly after arriving at the hospital, HIW were advised of a patient and two staff members who had tested positive for COVID - 19. As a result, the remaining two days of this inspection took place remotely and focussed on the following concerns:</p> <ul style="list-style-type: none"> • Management of Coronavirus (COVID-19) • Staffing levels • Staff welfare. 							

HIW completed a second unannounced inspection on the evening of the 20 September and the following days of 21 and 22 September 2021. This inspection focussed on what improvements had been made since the inspection on 6 September 2021. In addition, HIW also inspected the following areas:

- Infection Prevention Control
- Patient Care Plans
- Environment of care
- Governance and staffing.

HIW explored how the service met the Health and Care Standards (2015).

Attached to this cover paper is the inspection report, and the improvement plan developed in response to the findings.

HIW found positive practice:

- Staff interacted and engaged with patients respectfully
- Good team working and motivated staff
- Established governance arrangements.

HIW also found area the service needed to improve:

- The maintenance of the hospital facilities
- The capacity of its older adult inpatient mental health service
- Organisation and completion of care plans
- Improvements in welfare and morale of the hospital workforce
- A more stable and consistent senior management team
- Management of staff rota records.

Following the first inspection visit, HW escalated concerns and Immediate Assurances were requested. This response can also be found in the report.

Cefndir / Background:

HIW inspects the NHS in Wales, from general practices to hospitals. HIW assesses compliance against the Health and Care Standards 2015, the Independent Health Care (Wales) Regulations 2011, and National Minimum Standards (NMS) for Independent Health Care Services in Wales. They also have a specific responsibility to ensure that vulnerable people receive good care in mental health services. As such, HIW also inspect mental health and learning disability settings and considers compliance with legislation. HIW are also requested by HM Inspectors of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.

A paper is planned for the next Committee which will include the findings of an external, independent Serious Incident Review following an inpatient suicide at the unit. This paper will also include a short summary of triangulation between various reports about the unit.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Not applicable.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

NHS Mental Health Service Inspection (Unannounced)

Ysbyty Gwynedd

Hergest Unit

Betsi Cadwaladr University

Health Board

Inspection date: 6 – 8 September 2021 &
20 – 22 September 2021

Publication date: 23 December 2021



EMBARGOED UNTIL PUBLICATION

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:

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	Appendix C – Improvement plan	Error! Bookmark not defined.

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that people in Wales receive good quality healthcare

Our values

We place patients at the heart of what we do. We are:

- **Independent**
- **Objective**
- **Caring**
- **Collaborative**
- **Authoritative**

Our priorities

Through our work we aim to:

Provide assurance:

Provide an independent view on the quality of care

Promote improvement:

Encourage improvement through reporting and sharing of good practice

Influence policy and standards:

Use what we find to influence policy, standards and practice

1. What we did

Healthcare Inspectorate Wales (HIW) completed two unannounced mental health inspections of Ysbyty Gwynedd, Hergest Unit within Betsi Cadwaladr University Health Board. The first starting the evening of 6 September 2021, the second starting the evening of 20 September . The following sites and wards were visited during these inspections:

- Aneurin - Female acute mental health admission ward
- Cynan - Male acute mental health admission ward
- Taliesin - Psychiatric Intensive Care Unit (PICU)

Our team, for the inspection comprised of two HIW inspectors and two clinical peer reviewers. A HIW inspection manager led the inspection.

The first unannounced visit took place on the evening of Monday 6 September 2021. Shortly after arriving at the hospital, HIW were advised of a patient and two staff members who had tested positive for COVID - 19. As a result, the remaining two days of this inspection took place remotely and focussed on the following concerns:

- Management of Coronavirus (COVID-19)
- Staffing levels
- Staff welfare.

HIW completed a second unannounced inspection on the evening of the 20 September and the following days of 21 and 22 September 2021. This inspection focussed on what improvements had been made since our inspection on the 6 September 2021. In addition, we also inspected the following areas:

- Infection Prevention Control
- Patient Care Plans
- Environment of care
- Governance and staffing.

HIW explored how the service met the Health and Care Standards (2015).

Further details about how we conduct NHS mental health service inspections can be found in Section 5 and on our website.

2. Summary of our inspection

During our inspection commencing 6 September, we identified a number of areas of concern particularly around Infection Prevention and Control, and Governance and Leadership. Due to concerns about patient safety, we issued an immediate assurance letter, where we write to the service immediately after our inspection with our findings requiring urgent remedial action. We then returned to undertake a further unannounced inspection on 20-22 September to ensure the Hergest Unit was providing safe and effective care.

Overall, we found evidence that the Health Board had started to implement systems and processes to address areas identified in the immediate assurance issued. However, further improvements were identified in the inspection on the 20-22 September 2021.

We found a dedicated staff team that were committed to providing a high standard of care to patients. We observed staff interacting with patients respectfully throughout the inspection.

A number of environmental issues, a lack of infection prevention and control measures relating to COVID-19 procedures, and staffing issues were escalated during both inspections.

Improvements are required in completion of patient care plans and in maintaining accurate staff rota records.

Improvements in communication and engagement between senior managers and ward staff is required to develop a trusting relationship.

This is what we found the service did well:

- We observed that staff interacted and engaged with patients respectfully
- Good team working and motivated staff

- Established governance arrangements.

This is what we recommend the service could improve:

- The maintenance of the hospital facilities
- The capacity of its older adult inpatient mental health service
- Organisation and completion of care plans
- Improvements in welfare and morale of the hospital workforce
- A more stable and consistent senior management team
- Management of staff rota records.

Following the inspection on the 6 September 2021, HIW had some immediate concerns, which were dealt with under our immediate assurance process. This meant that we wrote to the Health Board immediately after the inspection, outlining that urgent remedial actions were required.

Details of the immediate improvements that were required are summarised below and the actions the provider has/is taking to address them are provided in Appendix B:

- We were concerned that some staff were working excessive hours and were regularly working beyond the end of their shift
- Staff informed HIW that they were not always having meal breaks during 12-hour shifts
- Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long-term leave. As a result, this impacted upon the capacity of the Psychiatric Liaison Team to undertake their role
- Staff rotas we reviewed highlighted a number of unfilled shifts
- There is no evidence of a ward acuity assessment to identify if current staffing levels were suitable for the current patient demands on the unit.
- HIW were not assured that all staff were aware of COVID-19 cases on the unit or that correct reporting mechanisms were in place

- As visitors on the unit HIW inspectors were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance
- Staff were not always following infection control protocols, for example, Security Guards were observed coming onto the unit from another area of the hospital. They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols
- Staff were being utilised from other areas of the hospital and across the Health Board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.

These are serious patient safety issues and we issued an immediate assurance letter to the health board following the inspection. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No new areas requiring immediate assurance were identified during the inspection on 20 September 2021.

3. What we found

Background of the service

The Hergest Unit provides NHS mental health services at Ysbyty Gwynedd, Penrhosgarnedd, Bangor, LL57 2PW, within Betsi Cadwaladr University Health Board.

The service has three wards:

- Aneurin, a 17 bed female acute mental health admission ward
- Cynan, a 17 bed male acute mental health admission ward
- Taliesin, a 6 bed mixed gender Psychiatric Intensive Care Unit (PICU).
- A dedicated Section 136 Suite¹.

At the time of our inspection, bed capacity had been reduced to help support social distancing measures required due to COVID -19. Aneurin and Cynan Wards bed capacity was 14 and Taliesin remained at 6.

The service employs a staff team, which includes a team of registered mental health nurses and healthcare support workers. The multi-disciplinary team consists of consultant psychiatrists and occupational therapists.

Dedicated teams of administration staff, maintenance, catering and domestic staff support the day-to-day operation of the hospital.

The hospital is overseen by the health board's clinical and administrative structures.

¹ Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. A Section 136 Suite is a designated place of safety.

Quality of patient experience

We spoke with patients, their relatives, representatives and/or advocates (where appropriate) to ensure that the patients' perspective is at the centre of our approach to inspection.

We observed staff interacting and engaging with patients appropriately, and treating patients with dignity and respect.

Patients we spoke to told us they were receiving good care at the hospital.

The health board needs to review the inpatient service provision for older adult mental health care, to ensure it has sufficient capacity and appropriate care to meet the needs of older adult mental health patients.

Staying healthy

There was a wide range of relevant information leaflets for patients, families and other visitors available in the reception areas of the unit and on the individual wards. These areas contained information on mental health issues, guidance around mental health legislation and physical well-being such as healthy eating. There was also information on organisations that can support patients, their families and carers.

Hergest Unit had a team of occupational therapists that provided a wide range of activities for patients within the unit. Each ward had their own designated garden area, which provided outdoor space for patients.

The unit had a therapies area, which included an activities area with a pool table and cardio exercise equipment, an arts therapy room, and a crafts room. However, at the time of the inspection we were informed that the gym equipment was not being used by patients due to restrictions relating to the COVID-19 pandemic.

Dignified care

We noted that all employees; ward staff, senior management and administration staff, interacted and engaged with patients appropriately and treated patients with dignity and respect.

The staff we spoke with were passionate about their roles and enthusiastic about how they supported and cared for the patients. We observed most staff taking time to speak with patients and address any needs or concerns the patients raised, this demonstrated that staff had responsive and caring attitudes towards the patients.

We noted locked doors and an intercom system on the entrance to the wards to prevent any unauthorised access. Taliesin was a Psychiatric Intensive Care Unit (PICU)² that had six individual bedrooms. Aneurin and Cynan were both designated as 17 bed acute admission wards; both were a mix of individual bedrooms and dormitory areas. At the time of the inspection, both wards were operating at 14 beds due to COVID–19 restrictions. Most patients had access to their own bedroom. However, there was one shared cubicle area on Cynan and Aneurin Ward. The three bedded cubicles had curtains between them, which only afford the basic level of privacy for patients and do not reflect modern mental health care provision.

There were bathrooms available on each ward that patients could utilise if they wished to have a bath. There were appropriate aids available to provide additional support for patients if required. On the first night of the inspection, we were told that the bath on Cynan Ward had not been working correctly. This matter was immediately brought to the attention of the health board and resolved during the inspection. There was also a blocked toilet on Aneurin Ward, which was also brought to the attention of the health board during the inspection.

Some of the bathroom areas on Aneurin and Cynan Ward were being used for storage, a number of boxes were positioned in corner areas of the bathroom. The health board must ensure that all items are stored in appropriate areas. In addition, three unused hospital beds were being stored in the reception area of Cynan Ward. This was brought to the attention of the health board and the beds were immediately removed.

² PICUs are designed to look after patients who cannot be managed on open (unlocked) psychiatric wards due to the level of risk the patient poses to themselves or others.

There was a patient status at a glance board³ in the nurse's office displaying confidential information regarding each patient being cared for on the ward. The boards are designed in such a way that confidential information could be covered when the boards were not in use. This meant that the staff team were making every effort to protect patient confidentiality.

Hospital policies and the staff practices we observed, contributed to maintaining patient dignity and enhancing individualised care at the hospital.

Improvement needed

The health board must ensure that

- The blocked toilet on Aneurin Ward, and the bath on Cynon ward are fixed
- Bathroom areas are not used for storage.

Patient information

We saw advocacy posters that provided contact details about how to access the service. Due to Welsh Government restrictions associated with COVID-19 legislation, Advocacy services were no longer visiting patients, however patients were able to contact a representative of the statutory advocacy service by telephone to speak to a representative.

Across all wards, we saw information relating to patient feedback and posters were displaying QR codes for patients to scan in order to provide feedback directly to the health board. Wi-Fi was available to facilitate this. In addition, there

³ A board that provides staff with a quick reference to essential information about the individual patients being cared for on the ward.

was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right⁴ process.

Communicating effectively

Patients we spoke with stated that they felt safe and able to speak with a staff member should they need to. Patients told us they were happy at the hospital and that staff were kind and helpful. There was clear mutual respect and strong relational security between staff and patients.

Through our observations of staff and patient interactions, it was evident that staff ensured that they communicated appropriately and effectively with patients. Staff took time to have discussions using words and language suitable to the individual patient. Where patients remained unclear, or what they were trying to communicate was misunderstood, staff would patiently attempt to explain what they had said.

For individual meetings, patients could have assistance from external bodies to provide support and guidance, such as solicitors or advocacy. With patients' agreement, wherever possible, their families and carers were also included in some meetings.

Timely care

Each morning there was an Acute Care Meeting involving all ward managers, multi-disciplinary team members, and representatives from the community services. Each patient being cared for at the hospital was discussed in turn.

Hergest Unit has a designated Section 136 suite where the police could bring people for a Mental Health Act assessment. This unit was closed on the 6 September, and patients were being re-directed to an alternative Section 136 suite in the health board. We were advised that the Section 136 facility had been on divert to Ablett and Heddfan units from 25 August 2021 – 7 September 2021. This had been agreed following discussion with North Wales Police.

⁴ Putting Things Right is the integrated processes for the raising, investigation of and learning from concerns regarding treatment within the NHS

The reason for the divert was staffing challenges arising from the COVID-19 positive patient requiring 2:1 nursing in an isolated ward next to Aneurin Ward. We were told that this is the contingency plan for all the Section 136 facilities and it is not usual practice for Hergest to divert due to staff shortages. The health board must ensure that there are always sufficient staffing numbers on duty to deal with any Section 136 admissions. Transporting a person further to a different Section 136 Suite within the health board is detrimental to the person's well-being.

The Section 136 suite was available for use on the unannounced inspection that took place on the 20 September and there were sufficient staff available to deal with a Section 136 admission.

The Section 136 Suite was adequately equipped to provide comfort and safety for a person awaiting and undergoing an assessment. There was a toilet available within the Section 136 Suite, however, there was no door or screen within the toilet entrance to afford privacy to a person using the facility. This had been highlighted as an area that needed improvement during our last inspection in 2018 but remains a significant dignity issue. The health board must ensure that this work is carried out.

The suite complied with the National Institute for Health and Clinical Excellence (NICE) standards, and the hospital ward and police had an agreed protocol on the use of the suite.

We were told meetings took place between the police and ward staff to evaluate admissions and frequency of use of the suite. It was positive to hear that any lessons learnt and organisational feedback would be discussed during these meetings. Close partnership working with the police and effective use of the Section 136 suite is essential to ensure that people presenting with mental health issues are getting the right care at the right setting.

Due to capacity demands across the health board older person's mental health service, there were occasions when older persons mental health beds were unavailable and therefore a person would be admitted to the adult acute admission wards where there was a bed available. Staff told us that there were also occasions when older persons with a diagnosis of dementia were admitted to the adult acute admission wards. The environment of care on acute mental health wards are not the most appropriate environment to meet the specific needs of those patients, lacking visual and orientation aids that are commonplace on dementia wards. Staff on acute mental health wards may also lack the skillset and be unfamiliar with providing care to patients with a diagnosis of dementia, in meeting their needs and managing their behaviours.

Staff spoken to raised concerns regarding the suitability of the environment of care and the complex challenges that present with older patient care. They described situations where some patients would require enhanced observations and different levels of physical care which staff may be unfamiliar with providing.

Improvement needed

The health board must ensure that:

- Section 136 suite remains open and there are sufficient staff available to cover admissions
- There is appropriate privacy measure for the toilet located in the Section 136 Suite
- A pathway is developed in the health board for older adult care.

Individual care

People's rights

Patients could also utilise the Independent Mental Health Advocacy (IMHA) service where a representative could be contacted via telephone or when they attended the hospital. We were told that advocacy were not currently attending the wards, however were available by telephone for patients to make contact.

During the course of reviewing patient records, we noted that there were no capacity assessments being recorded. Therefore, there was no record to determine if the patient had capacity to make informed decision around:

- Administration of medication within the ward environment
- Understanding the inherent restrictions of being admitted onto a locked ward.

Established hospital policies and systems ensured that patients' equality, diversity and rights are maintained. Information was displayed on the wards to

inform patients, who were not restricted by the Act⁵, about their rights to leave the ward.

Due to Welsh Government restrictions associated with COVID-19 legislation, visitors were not allowed on to the unit. However, some patients could meet with family and friends within the hospital grounds. Other patients could maintain contact with family and friends by telephone and video calls.

There was a designated area for children and families visiting which was off ward. This meant that patients could meet with younger family members away from the ward environment.

Improvement needed

The health board must ensure that capacity assessments are completed and recorded in patient records.

Listening and learning from feedback

There was the opportunity for patients, relatives and carers to provide feedback on the care provided via the NHS Putting Things Right process. Senior ward staff confirmed that wherever possible they would try to resolve complaints immediately.

There was no evidence of regular patient meetings taking place, where patients would have the opportunity to discuss any improvements or patient initiatives.

It was positive to note that there was a large display of thank you cards on display in the nurse's office.

⁵ Commonly referred to as "informal patients", where the patient has capacity to agree to remain in hospital to receive care for their mental health.

Improvement needed

The health board must put a system in place for patient meetings with ward staff.

Delivery of safe and effective care

We considered the extent to which services provide high quality, safe and reliable care centred on individual patients.

Whilst overall the physical environment at Hergest Unit was maintained to a good standard, we identified a number of areas that require action.

We also identified areas for improvement concerning staff practice, in particular around completion of care plans to evidence in detail the care being provided.

Safe care

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process. This meant that we wrote to the health board immediately following the inspection requiring that urgent remedial actions were taken. Details of the immediate improvements we identified are provided in Appendix B.

No immediate assurances were identified when we return to Hergest on the 20-22 September 2021.

Managing risk and promoting health and safety

There were established processes in place to manage and review risks, and to maintain health and safety at the hospital. This assisted staff to provide safe and clinically effective care.

The Hergest Unit is located within the grounds of Ysbyty Gwynedd with its own entrance and staffed reception during the day. During the evening and night, the entrance to Hergest Unit is secured to prevent unauthorised entry, during these times the wards can be contacted via the intercom located at the entrance. However, when the inspection team arrived unannounced on the first evening on 6 September 2021 we were let through the locked doors on to the ward without being asked for identification. Staff must act with vigilance and ensure that the identity of visitors is confirmed prior to allowing their access on to the ward. It was positive to note that on the second unannounced visit, identification was requested.

The inspection team considered the hospital environment during a tour of the hospital on the night of 20 September 2021 and the remaining days of the inspection. We identified a number of decorative and environmental issues that required attention, these included:

- Sticky tape residue marks where items had been stuck to doors and windows. This unfortunately left the wards, in parts, looking scruffy and unkempt
- Plaster flaking on walls both sides of garden entrance door to Cynan Ward
- Plaster flaking and dampness near the external entrance door to 136 suite
- Cluttered and disorganised storage cupboards
- Hot water tap not working in kitchen on Aneurin Ward
- Patient bathrooms being used as additional storage areas.

These issues were brought to the attention of the health board and the estates team were notified. The health board must ensure that the environmental and decorative issues are resolved.

We told that some of the wards on Hergest had high-low profiling beds to assist in maintaining the safety of patients with reduced stability and mobility. We were told that risk assessments were in place for individuals who use these beds; however, it was unclear if risk assessments had been completed for other individuals on the wards that could gain access to these beds. Staff had access to personal alarms to call for assistance if required, there were also nurse call points around the hospital so that patients could summon assistance if required.

There were established systems in place for assessing and monitoring patients' level of agitation, and staff were trained in recognised Restrictive Physical Intervention (RPI) techniques for managing patient behaviours. Senior staff confirmed that the physical restraint of patients was used, but this was rare and only used as a last resort.

There was an established electronic system in place for recording, reviewing and monitoring incidents. Incidents were entered on to the health board's incident reporting system (DATIX) that included the names of patients and staff involved, a description, location, time and length of the incident. Any use of restraint was documented.

There was a hierarchy of incident sign-off with regular incident reports produced and reviewed so that occurrence of incidents could be monitored and analysed.

We attended a Putting Things Right meeting. Incidents, safeguarding, staffing and Infection Prevention Control were among the items discussed. It was reassuring to see and hear senior management discussing issues during this meeting, however, no members of the ward staff were available at this meeting. It would be beneficial if ward staff were provided with an opportunity to represent themselves at these meetings. This would ensure that ward staff have an opportunity to contribute to discussions and improvements made with the senior management team.

There were up-to-date ligature point risk assessments in place for the wards. These identified potential ligature points and what action had been taken to remove or manage these. We reviewed records and confirmed there was evidence of audits.

Improvement needed

The health board must ensure that:

- Staff confirm the identity of visitors prior to allowing access on to the ward
- Sticky residue is removed from windows
- Re-plastering is completed on Cynan Ward and Section 136 suite
- Storage cupboards on all wards are organised
- Patient bathrooms are not used as additional storage areas
- Hot water tap on Aneurin Ward is fixed
- There are regular environmental audits to identify any unreported damaged areas
- Representation from ward staff at meetings.

Infection prevention and control

We found that the arrangements for the prevention and control of infection within Hergest Unit did not protect potential transmission of COVID-19 to other patients and visitors. During the unannounced visit on 6 September, the inspection team

questioned if there were any COVID -19 cases on the ward. We were told that one positive patient was being nursed in isolation. However, the inspection team were later advised by another member of staff that two members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that the correct reporting mechanisms were in place.

In addition, as visitors on the unit, we were not advised to adhere to COVID-19 protocols, such as hand hygiene compliance. We also observed security guards coming onto the unit from another area of the hospital. They were not wearing masks correctly and went straight onto one of the wards without complying with hand hygiene protocols. We also identified that staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues at Hergest. It was unclear what procedures were in place to prevent any potential transmission of infection from other areas of the hospital.

Our concerns regarding management of COVID-19 and staffing issues from the inspection on 6 September 2021 were dealt with under our immediate assurance process.

Following the unannounced inspection on the 6 September 2021, HIW were provided with evidence to confirm that the health board conducted necessary risk assessments and updated relevant policies and procedures to meet the additional demands of the COVID-19 pandemic. We also examined COVID-19 documents, which supported staff to ensure they remained compliant with policies and procedures.

When we returned unannounced on 20 September 2021, we noted improvements. Staff were checking that we had complied with COVID-19 protocols such as hand hygiene and wearing and changing of face masks. Staff were also aware of the COVID-19 status of the unit.

On the 20 September 2021, two patients were being nursed in the isolation suite. We were unable to inspect this area but through glassed doors, we were able to observe staff donning PPE in an area outside the isolation suite. The PPE was being stored on a table outside the isolation suite. The acute manager told us of further improvement plans she was implementing in the isolation area. This included separating a room into designated donning and doffing areas and estates were fitting a cupboard in this area to store supplies of PPE. The health board must provide an update on the further improvements the health board are making to the isolation suite.

Staff we spoke to were aware of infection control obligations. We were told by staff and saw evidence of staff policies relating to self- isolation, and COVID-19

workforce risk assessments. We were also told that any staff who tested positive were discussed at safety huddles, and Datix incidents would be completed. In addition, a 72-hour review would be undertaken to ensure that appropriate safeguards were in place to protect staff and patients. Regular communication via emails ensured everyone has up to date advice and guidance on COVID-19.

Weekly cleaning audits and daily hand hygiene audits were carried out on the unit. The acute care manager also completes a daily walkabout with the senior leadership team on a weekly basis. Any breaches or issues are addressed directly with staff and with ward/team managers. In addition, external audits are undertaken by external health board staff to ensure compliance. The nursing team were very complimentary of the domestic staff and we were told that they all worked well together as a team.

Cleaning equipment was stored and organised appropriately. There were suitable arrangements in place for the disposal of clinical waste. Bins were available to dispose of medical sharp items and these were not overfilled.

Improvement needed

The health board must ensure that:

- All staff check visitors compliance with COVID-19 procedures
- Isolation suite has suitable storage for PPE
- HIW are provided with details of improvements made to the isolation suite.

Nutrition and hydration

Patients were provided with meals at the hospital making their choice from the hospital menu, and had access to drinks and fresh fruit on the wards. The patients we spoke with were positive about the food provided.

We were told that specific dietary requirements were accommodated and if patients missed mealtimes, they would be provided with sandwiches. Staff said patients make their food choices in advance and stated if a patient changes their mind, they can usually be accommodated with another option.

The dining room was clean and tidy and provided a suitable environment for patients to eat their meals. We were also told that patients could also eat meals in their rooms to help with social distancing measures.

Medicines management

Overall, we noted that medication was securely stored. Staff locked the clinic room and medication cupboards to prevent unauthorised access. The automated medication dispensing cabinet was not working correctly on Aneurin ward, however staff were still able to dispense medication. This issue had been reported and was resolved whilst the inspection was ongoing.

Staff locked medication fridges when not being accessed. There was evidence of regular temperature checks of the medication fridge to monitor that medication was stored at the manufacturer's advised temperature. However, we saw that on both Aneurin and Taliesin wards, the fridge temperatures recorded were outside the required range but staff had not escalated this. This was immediately raised by HIW and both fridges were fixed. The health board must ensure that fridge temperatures are in the required range to ensure that medication is stored at the correct temperature.

Staff told us that since the installation of the automated medication dispenser unit, the temperature of the clinic in the summer months could be high. We noted that no ambient room temperature checks of the clinical room were routinely monitored or recorded on Aneurin Ward. It is important that temperature checks of the clinical room are taken and recorded to ensure that medication is not affected by temperatures outside of the manufacturers' stated temperature range.

There were regular stock checks of medication, including Controlled Drugs and Drugs Liable to Misuse, to ensure that the correct amounts were present. A number of liquid medicines on Taliesin Ward were reviewed, these were appropriately stored, however they were not labelled with a date of opening. It is important that dates of opening are recorded on liquid medication as this may affect the shelf life and quality of the medication.

There was a regular pharmacy input, and audits were undertaken, which assisted the management, prescribing and administration of medication. We observed a number of medication rounds, and saw that staff undertook these appropriately and professionally, and interacted with patients respectfully and considerately.

The majority of Medication Administration Records (MAR Charts)⁶ reviewed were fully completed by staff. This included completing all patient details on the front and subsequent pages and their Mental Health Act legal status. However, on one patient chart the allergy section stated 'as per GP record'. This would require the nurse to look at the GP records, when all allergies should be recorded on the drugs chart to prevent any drug induced allergic reactions. It is important that any allergies and information are documented on patient charts.

A Medication Management Policy was not available in the clinic and staff were unable to demonstrate where the policy was kept. The health board must make sure that all staff understand the policy, are familiar with the content and that a copy of the policy is available in the clinical area.

Staff had access to all relevant medicine management policies at the hospital along with the current British National Formulary (BNF)⁷.

There were regular checks of resuscitation equipment. Staff had documented when these had occurred to ensure that the correct equipment was present and in date.

Improvement needed

The health board must ensure that:

- Staff record fridge and clinical room temperatures
- Any fridge or clinic room temperatures outside the required range are addressed

⁶ A Medication Administration Record is the report that serves as a legal record of the drugs administered to a patient by a health care professional. The Medication Administration Record is a part of a patient's permanent record on their medical chart.

⁷ British National Formulary is a pharmaceutical reference book that contains a wide spectrum of information and advice on prescribing and pharmacology, along with specific facts and details about individual medicines.

- Management investigate the raised temperature in clinical room
- Dates of opening liquid medications are recorded
- Allergies are clearly specified on drug charts
- Staff are aware of the location and content of the medication management policy.

Safeguarding children and adults at risk

There were established health board policies and processes in place to ensure that staff safeguarded vulnerable adults and children, with referrals to external agencies as and when required.

Ward staff had access to the health board's safeguarding procedures via its intranet. Senior ward staff confirmed they were confident that staff were aware of the correct procedure to follow should they have a safeguarding concern. During discussions with staff, they were able to demonstrate knowledge of the process of making a safeguarding referral. As highlighted above all safeguarding referrals are discussed during the putting things right meeting where the health boards safeguarding lead would be present.

Medical devices, equipment and diagnostic systems

There were regular audits of resuscitation equipment undertaken on each of the wards when required, which documented that all resuscitation equipment was present and in date.

There were a number of ligature cutters located on each of the wards, for use in the event of an emergency. During the inspection, all staff we spoke with were aware of the location of ligature cutters.

Effective care

Safe and clinically effective care

Overall, we found that systems and governance arrangements were in place, which helped ensure that staff provided safe and clinically effective care for patients. However, as detailed within the report the health board needs to address the deficiencies identified during the inspection and these are detailed, along with the health board's actions, in Appendices A, B and C.

Record keeping

Patient records were mainly paper files that were stored and maintained within the locked nursing office, with some electronic documentation, which was password protected. We observed staff storing the records appropriately during our inspection.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision

We reviewed the Care and Treatment Plans of four patient records provided to us after the unannounced inspection on 6 September 2021, and five patient records were viewed during the unannounced return on the 20 September 2021.

We highlighted a number of errors in the care plans reviewed from both inspections.

The unmet needs of patients were not identified. It is important that any unmet needs are documented, so that these can be regularly reviewed by the multidisciplinary team. It is important to consider options for meeting all needs, as this may result in identifying an alternative placement.

We also noted a number of missing observation recordings in observation recording forms. Signatures of observing staff were missing and forms contained gaps with no entries. During one set of patient notes the fluid balance (input/output) charts, had some discrepancies where the charts had been poorly completed or were incomplete. The charts inspected did not provide sufficient information to document the patients' consumption over a period of time and it was difficult to establish if this patient had access to appropriate amount of fluids. In addition, the care plans did not adequately cover the following areas:

- No date of review was recorded on some care plans
- No evidence of physical assessments taking place
- No entries to show if patient had capacity to agree to treatment plan
- COVID–19 care plans were signed but not fully completed.
- Care co-ordinators were unnamed and just recorded as nursing staff.

The health board must ensure it addresses all the deficiencies with care plans to ensure that accurate and historical data is captured and recorded.

Improvement needed

The health board must ensure that:

- Unmet needs are evidenced and documented within patient care plans.
- Observation record sheets are accurately completed
- Food and fluid charts are completed in full and accurately recorded
- Review dates are recorded in care plans
- There is evidence of physical assessments taking place
- That capacity assessments are completed
- COVID–19 care plans are fully completed
- Care co-ordinators are identified and named.

Quality of management and leadership

We considered how services are managed and led and whether the workplace and organisational culture supports the provision of safe and effective care. We also considered how the service review and monitor their own performance against the Health and Care Standards.

Throughout the inspections and at the feedback sessions, staff and management at Hergest Unit were receptive to our views, findings and recommendations.

Throughout the inspections, staff demonstrated their commitment to provide care for patients within the hospital. However, we are concerned that some staff may be working excessive hours and not taking their required breaks. Fatigue may affect staff well-being and impact upon professional judgements.

Improvements are required in relation to maintaining accurate staff rota records.

We also noted that findings from other inspections within the health board were replicated at Hergest. This identifies a lack of joint learning by the health board on the outcomes of inspections.

Governance, leadership and accountability

The significance of the areas of improvement identified in the below Workforce section, along with Infection Prevention and Control, and Care Planning sections of this report, highlights the need for improvement in audit and governance regarding these areas to support patient safety.

Throughout interviews with staff, it was clear that working relationships built on trust had not yet been fully developed between the ward staff and health board senior management teams. This was partly due to a number of significant changes to the management and multi-disciplinary team. In addition, staff we spoke to raised concerns around the quality of communication from senior leaders around recent staff movements on Hergest Unit. The health board must

ensure it has a communication strategy in place to brief staff when any changes are made.

During interviews with staff, we were told that changes in the senior management teams made it difficult to build up working relationships that allowed them to raise confidential issues or concerns. There was a clear lack of trust in senior management from the ward staff who described working in a culture of blame; this feeling amongst staff was having a significant impact on staff morale and well-being.

Some staff described being 'petrified' of making mistakes and were fearful that they would be redeployed or suspended from duties. However all staff spoke positively about their immediate line managers and described working in resilient and supportive teams.

We spoke to ward staff and were told that they escalated some environmental and patient care issues to management. They also told us they were not confident these issues would be dealt with. However, senior staff informed us that they were unaware of these issues. It is unclear if this difference is due to a lack of structured escalation procedures, or a lack of confidence from ward staff in the senior team. The health board must provide a system for escalation of issues for staff to follow, including regular updates of actions taken by management. This system should be clearly communicated to all staff.

The health board have appointed a Clinical Operations Manager, along with a Head of Nursing and Clinical Acute Care Manager. Discussions held with these individuals and the Interim Director of Mental Health highlighted that they were aware of issues on Hergest Unit that require improvement. They indicated they had a commitment to addressing these to raise the standard of the environment and treatment and support to patients and staff.

Senior staff advised us of initiatives they were developing to try to support staff well-being. In order to bridge the gap between senior management and ward staff, senior managers were ensuring that they were a visible presence on the ward and were making efforts to build up confidence and trust between ward staff and senior management. However it was evident through interviews with staff that they did not feel valued or supported by senior management. The health board must ensure that its senior leaders encourage professional integrity, inclusive and supportive relationships so that staff feel valued, respected and confident to report concerns. In order to achieve this the health board needs to provide a stable and consistent senior management team for staff on Hergest Unit.

At the time of the inspection there was no permanent consultant psychiatrists nor psychologists in post, the health board had arranged cover for these positions. However, this had been sporadic and had not provided consistency of care. Ward staff we spoke to told us that they did not feel involved in decisions around patient care and treatment that were being made by the consultant psychiatrists.

As a result there was a lack of collaboration between the disciplines, and whilst there was also occupational therapy input, there was no evidence of cohesive multi-disciplinary team working. The lack of an established multi-disciplinary team impacts negatively on patient care and safety. Patients were not getting timely access to the range of care and support they need. The lack of MDT collaboration also prevents ward staff, including newly qualified nurses, developing clinical judgement skills.

It is vitally important that the health board ensure that the staff at the hospital work together and become a more cohesive team who communicate, consult, and make decisions together to optimise patient care.

A key finding from our our last Mental Health Inspection of Wrexham Maelor Heddfan Unit in July 2020 was a lack of communication and consultation between senior management and ward staff. This highlights a lack of shared learning from other inspections within the health board.

Improvement needed

The health board must ensure that:

- Senior management and ward staff work together to build up confidence and trust
- Senior management improve communication with staff
- MDT work collaboratively with ward staff
- Consistent and stable senior management team is maintained.

Staff and resources

Workforce

During the unannounced inspection on the 6 September 2021, we were given conflicting information on the staffing numbers and the observation needs of the patient group. The health board subsequently provided us with accurate data on the staff who were working on the night of the inspection and the observational levels required. This data reflected that there were sufficient staffing levels to meet the needs of the patient group. However, this was only because staff were not taking their breaks and some staff were working extra hours after their rostered shift to support their team members. Details on the health boards' response are included in Appendix B.

Further examination of previous rotas indicated unfilled gaps. The health board told us that these gaps had been filled with staff, however, this was not reflected on the rotas we examined. The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded, and historical data on resources is captured.

Staff told us that they would often work beyond their rota'd shifts to support colleagues due to staffing shortages. Staff indicated that there were occasions where they felt staffing levels were too low, in particular at night-time and on weekends. In addition, we were told that staff were working through their breaks as they felt it was unsafe to take a break and they were fearful of leaving colleagues short staffed on the unit. This type of working environment will lead to fatigue and affect staff well-being, compromise their professional judgements and impact on patient safety.

Senior management confirmed that they were encouraging staff to have breaks by discussing breaks during morning meetings and arranging coverage on the wards for staff to have breaks. In addition, senior management had developed a weekly accountability meeting where they look at hours staff worked to try and alleviate staff working excessive shifts and becoming fatigued. However, staff told us that even though management were telling them to have breaks they did not always feel that the unit would still be safe if they went on break. This was due to the acuity of patients and staffing levels. The health board must ensure there are sufficient staff to meet the demands of the patients.

During conversations with senior management, it was unclear when the most recent review of safe staffing numbers had taken place on Hergest Unit. This should be based on the current acuity levels and changing demands on the unit. Safe staffing is a fundamental part of good quality care and it is important that the health board undertake a review of its staffing establishment on Hergest Unit, including the S136 suite.

Senior staff confirmed that there were a number of registered nurse vacancies and recruitment had been ongoing for these posts. There were also a number of staff who had been temporarily redeployed or absent due to sickness. Therefore, additional resources were required to fulfil staff rotas. Where possible the ward utilised its own staff and regular registered nurses from the health board's bank staff.

There was a lack of staff break facilities on the unit, and those available were small and cluttered. In addition, due to limited storage space across the unit, staff rooms for the unit included items that should be stored elsewhere. This meant that there were limited suitable places where staff could take their breaks.

Staff told us that team meetings were not taking place. This was something the acute care manager told us she was looking to improve upon. The health board must ensure that regular team meetings can take place, this should be planned in order to make this a more meaningful, supportive and valuable process for staff.

The training statistics reviewed identified low compliance with some modules on Aneurin Ward. For example, the compliance rates for fire safety was 44%, Information Governance was 51% and Moving and Handling was 48%. In addition, compliance with staff appraisals was only at 68%. We have recognised that the figures on Aneurin Ward may be due to staff absences and that face-to-face training has been difficult due to the pandemic, however, improvements are still required in these areas.

It was positive that, throughout the inspection, staff engaged openly and were receptive to our views, findings and recommendations.

Improvement needed

The health board must ensure that:

- Staff do not work excessive hours
- Staff have breaks and feel confident leaving the ward for breaks
- There are appropriate areas where staff can take their breaks
- Staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.

- That there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times
- Mandatory training figures are improved
- Regular team meetings take place for staff.

4. What next?

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas

The improvement plans should:

- Clearly state when and how the findings identified will be addressed, including timescales
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

5. How we inspect NHS mental health services

Our inspections of NHS mental health services are usually unannounced. We will always seek to conduct unannounced inspections because this allows us to see services in the way they usually operate. The service does not receive any advance warning of an unannounced inspection.

Feedback is made available to service representatives at the end of the inspection, in a way which supports learning, development and improvement at both operational and strategic levels.

HIW inspections of NHS mental health services will look at how services:

- Comply with the [Mental Health Act 1983](#), [Mental Capacity Act 2005](#), [Mental Health \(Wales\) Measure 2010](#) and implementation of Deprivation of Liberty Safeguards
- Meet the [Health and Care Standards 2015](#)

We also consider other professional standards and guidance as applicable. These inspections capture a snapshot of the standards of care within NHS mental health services.

Further detail about how HIW inspects [mental health](#) and the [NHS](#) can be found on our website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
We found the bath was not working on Cynan Ward	Patients were unable to use the bath	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection
We found that the toilet was blocked on Aneurin Ward	Patients were unable to use the toilet	We raised this concern with the health board during the inspection and requested this was immediately resolved.	The health board immediately resolved this issue during the inspection.
We found that the temperature on the fridges in both clinical rooms were not within the required temperature ranges	Medication may not have been stored correctly	We raised this concern with the health board during the inspection and requested this was immediately resolved	Both fridges were fixed and medication was being stored safely on the ward

Appendix B – Immediate Improvement plan

Service: Ysbyty Gwynedd

Area: Hergest Mental Health Unit

Date of Inspection: 6 – 8 September 2021

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
Quality of patient experience				
No immediate concerns identified at this time.				
Delivery of safe and effective care				
HIW were not assured there was sufficient staffing to provide appropriate clinical care to support and maintain the safety of the ward. The health board must ensure the wards have a sustainable staffing model with the required levels of expertise to meet the clinical needs of all patients.		A Divisional Inpatient Establishment review has recommenced, which was stood down in 2020 due to Covid-19 pandemic priorities. This will enable an understanding of staffing requirements across the Division and a model to be agreed to ensure safe delivery of care in all Divisional inpatient settings.		

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		Action: 1. Local Senior Leadership (SLT) to review and submit their inpatient staffing establishment template to inform the overall Divisional inpatient establishment review. 2. Reaffirm the staffing escalation process across the unit and the Division as a whole. 3. Information sessions to be held with all Hergest unit/ward leads to ensure a strengthened understanding of the Hergest Standard Operational Procedure (SOP), to enable consistent implementation. 4. Continue to progress with the “Stronger Together” Discovery phase across the Division, to give staff the opportunity to work together to shape how the organisation works. This will include attendance at workshops.	Head of Operations (HON)/Head of Nursing (HOP) Director of Operations (DOP)/ Director of Nursing (DON) HOP/HON DOP/DON DOP/DON	24/09/21 20/09/21 15/10/21 31/12/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
<p>We talked to staff throughout the inspection and examined staff rotas. We identified significant staffing issues on the unit, these were:</p>		5. Progress with a Divisional communication campaign aligned to the “Speak out safely” initiative, so staff are aware and are supported in raising any concerns across BCUHB. This will enable staff to use a confidential and anonymous platform to raise any concerns.	Divisional Head of Workforce (DHOW)	30/10/21
		6. Raising awareness with the Respect and Resolution policy as part of developing health working relationships in the workplace.	DHOW	31/11/21
		7. Progress with the Maturity Matrix approach to track improvement across the Division.	DOP/DON	15/09/22
		Current position When the ward rosters are initially completed and signed off, staff		

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
<p>Staff were working excessive hours and were regularly working beyond the end of their shift.</p>		<p>are not rostered to work excessive hours. For any additional hours worked this is in addition to contracted hours which staff have agreed to undertake through either bank or overtime.</p> <p>Action:</p> <p>8. Local arrangements to be implemented to ensure a robust system is in place to closely monitor, review and address timely any issues in relation to staff working excessive hours and with regularity working beyond their shift, to ensure staff wellbeing in work.</p> <p>9. A Divisional standard template to be developed to inform decision making regarding authorisation of additional shifts for staff.</p>	<p>HOP/HON</p> <p>DHOW</p>	<p>30/09/21</p> <p>15/10/21</p>
<p>Staff informed us they were not always having meal breaks during 12 hour shifts. They had notified management of this but the situation had not changed.</p>				

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
Staff were being used from Psychiatric Liaison Teams to fill rota gaps on the wards to cover sickness and staff long term leave. As a result this had impacted upon		<u>Current position - Meal Breaks</u> The interim SLT have recently been made aware regarding this issue and have commenced renewed focus to ensure that staff are taking their breaks appropriately.	Acute Care Site Manager (ACSM)	17/09/21
		Action: 10. Strengthen the escalation and action in the daily Acute Care Meeting (ACM) for any issues regarding staff breaks.	DON/DOP	15/10/21
		11. Through an agreed cycle of business and through a range of communication means i.e. Memo, Staff Briefing, visit to units, staff forums, including the Joint Partnership Forum with staff side partners and Wellbeing Hubs, highlight the importance of staff wellbeing in work and to limit working excessive hours, the importance of	ACSM	18/10/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
the capacity of the Psychiatric Liaison Team to undertake their role.		<p>staff taking their breaks and reaffirm the appropriate escalation processes.</p> <p>12.To ensure the importance of working reasonable hours and meal breaks are included in the Staff Induction Pack within the staff Wellbeing Section and also include as part of the checklist for staff supervisions.</p> <p><u>Current position regarding utilisation of Psychiatric Liaison staff</u></p> <p>In order to provide safe staffing on inpatient environments, there has, on occasion, been the need to use Psychiatric Liaison staff overnight for duty nurse purposes. However, this is considered in relation to the number of liaison nurses on duty to ensure there is a psychiatric liaison service available to the District General Hospital (DGH). In addition, to ensure continuity of service, the doctor on duty will hold the Psychiatric Liaison bleep to be able to support any assessments required.</p>	<p>HOP/HON</p> <p>ACSM</p>	15/10/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
<p>Staff rotas we reviewed highlighted a number of unfilled shifts, for example the shifts for the 6th of September showed that there were 5 unfilled HCA night shifts on Aneurin Ward and 2 HCA night shifts on Taliesin Ward. Similar gaps were highlighted from rotas provided to us for week commencing 6th-11th September 2021 with no staff allocated to some shifts.</p>		<p>Action:</p> <p>13. Review of the current SOP and the Business Continuity Plan to ensure clarity of the mitigation plans to support continuity of services.</p>	HOP/HON	17/09/21
		<p>14. The Interim Hergest SLT to ensure discussions are routinely taking place regarding safe staffing levels in daily ACM and Safety Huddles, and that appropriate mitigation and/or escalation is in place where required.</p>	DON/DOP	Completed
		<p>15. To continue to ensure a member of the SLT, or the duty nurse at the weekends, routinely attend the ACM and Safety Huddles and escalate any issues to the Divisional Huddle or Bronze on-call at weekends.</p>	HOP	
		<p>16. Reaffirm the requirement aligned to the MH&LD Staffing Escalation Policy across the Division.</p>		23/09/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		<p>17.To monitor and review key performance indicators aligned to Psychiatric Liaison to address any issues where required.</p> <p><u>Current Positon regarding unfilled shifts</u> Unfilled shifts were covered via redeployment of staff from other areas. These were additional staff to the rostered numbers on the E-Roster system e.g. the Duty Nurse was based on the ward. Likewise, other staff were deployed from other areas to enable safe staffing, again these staff would not show on the Hergest E-Roster as they were on the E-Roster for other areas.</p> <p>The current agreed staffing establishment for the three wards in Hergest unit is:-</p>	HOP/HON	30/10/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
<p>It was not evident that up to date ward acuity assessments had been completed to identify the required staffing levels. It is unclear if the current staffing levels were suitable for the current acuity and patient demands on the unit.</p>		<p>Aneurin 5/5/3 - 17 established beds (also one escalation bed).</p> <p>Cynan 5/5/3 - 17 established beds (also one escalation bed).</p> <p>Taliesin 5/5/4 - 6 beds.</p> <p>Having reviewed the staffing position, none of wards on the evening of 06/09/2021, at the time of the inspection, were below the staffing template. Further to this, the staffing template is based on 18 patients for both Aneurin and Cynan, and the bed occupancy at the time of the inspection was 14. Also to note, both Cynan and Taliesin on 06/09/2021 were over establishment for HCSW's *</p> <p>Action:</p> <p>18. Through communication and engagement with key unit managers, ensure that there is –</p>	ACSM	

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
Staff were unclear what the escalation arrangements were and how to contact an on-call doctor.		<ul style="list-style-type: none"> a. Clear understanding of the E-Roster processes. b. Timely E-Roster sign-off to enable all additional shift requirements identified to be processed to bank office. c. Putting in place scrutiny on E-Roster controls reporting through to HON and HOP. <p>19. Reaffirm the requirement for Ward manager to escalate any unallocated shifts within the agreed timeframe to daily ACM huddle for discussion and agreement of any action/mitigation to be put in place.</p> <p>Current position aligned to ward acuity assessments The ACM discuss and agree staffing levels required based on patient acuity. Ward managers/representative for the ward provide an overview of their ward staffing requirements to ACM, which feeds into the daily Safety Huddles.</p>	Ward Manager	25/09/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		<p>Action:</p> <p>20. To ensure the bed flow twice weekly meeting includes ward acuity assessments to plan safe staffing levels for the forthcoming days.</p> <p><u>Current position aligned to escalation arrangements</u></p> <p>Current on-call arrangements include a unit bleep holder, bronze on-call, silver on-call and medical on-call. A rota is circulated on a monthly basis for all these positions, and more frequently if changes or gaps occur. The silver on-call was established at the beginning of the Covid pandemic to provide additional advice and support to the bronze on-call due to the increase in activity across the Division.</p> <p>Bronze and silver on-call communicate on a regular basis as required, and bronze on-call attend local area Safety Huddles and site meetings during their on-call period.</p>	<p>DOP</p> <p>HOP/HON</p> <p>HOP</p> <p>DHOW</p>	<p>17/09/2021</p> <p>25/09/21</p>

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		<p>There is a Consultant on-call rota and junior doctor on-call rota, with contact details. The rotas are communicated, there is a pan-Division distribution list and this is evident in the duty nurse room and on the ward areas*.</p> <p>21.Divisional memo to be circulated to reaffirm the escalation procedure for on-call arrangements.</p> <p>22.To include this issue in the communication and engagement session with the ward/unit leads.</p> <p>23.To ensure this is included in the Hergest SOP.</p> <p>24.Review the current staff mapping undertaken during the second surge of Covid-19 for all staff within the Division for options of deployment.</p>		

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
				25/09/21
				25/09/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
				15/10/21
				15/10/21
HIW were not assured that there were established Infection Prevention and Control measures in place to manage and mitigate the risks posed by Covid-19. The health board must ensure that all internal and national Covid-19 policies and measures are complied with to ensure the safety of patients, staff and visitors.		<p>The safe management of Covid-19 in the MH&LD Division has incorporated a Covid-19 Social Distancing Action Checklist and Action Card which provides assurance the Covid-19 guidance has been applied across the Division. An escalation, communication and cascading process is in place with ACM, Daily Safety Huddles, Divisional Huddles, MH&LD Briefings and BCUHB announcements. Daily submission of SITREP including PPE audits, monthly Infection Prevention and Control (IPC) audits and walk around of IPC in all inpatient areas.</p> <p>MH&LD Division has the highest compliance in BCUHB for Covid-19 risk assessments.*</p>		

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
<p>On arrival the inspection team questioned if there were any Covid-19 cases on the ward and were told of one positive patient being nursed in isolation. However, the inspection team were later advised by another staff member that two further members of staff had tested positive across the unit. We were not assured that all staff were aware of the cases on the unit or that correct reporting mechanisms were in place.</p>		<p>Current position aligned to Covid-19 Cases</p> <p>A patient tested Covid-19 positive on admission on 24/08/2021. In line with policy, the patient was isolated and nursed for the incubation period, returning to the ward once this had ended and advice sought from our IPC team. There were two patients who were considered contacts; one with this particular patient and another who had a socially distanced visit outside with her father, under staff supervision. Her father subsequently tested positive for Covid-19, and following advice from our IPC team the patient was considered to be a contact as a precaution. Both patients were nursed individually in their rooms as per guidance by the IPC team and the unit Covid-19 Standard Operating Procedure (SOP). Neither patients have subsequently tested positive for Covid-19 and the patients are now able to utilise the ward area, with the 2:1 support arrangements to manage the situation, ending on</p>		

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
<p>As visitors on the unit we were not advised to adhere to Covid-19 protocols, such as hand hygiene compliance.</p>		<p>Monday 06/09/2021. This corresponds with the reported daily SITREP position.*</p> <p>No staff were working at the time of the inspection who were Covid-19 positive.</p> <p>Current position aligned to visitors to the Unit Covid-19 Guidance posters are clearly visible which are displayed at the Hergest entrance and within the foyer. Each ward entrance also has posters aligned to hand washing and mask wearing. An IPC station is immediately noticeable upon entering the Hergest unit at the foyer, with a stock of hand sanitizer and masks.</p> <p>Aligned to current guidance all visits to the MH&LD are prearranged with agreement by the staff on the unit. A visiting record is completed by the staff and visitors and the visitor log updated. Corporate Covid-19 signage and posters have been provided to all units to advise visitors of the IPC requirements in place when visiting units. There is a</p>		

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		<p>requirement that all visitors to the unit are booked in advance.*</p> <p>Guidance on visitors to wards has been shared with staff via the MH&LD Staff Briefing, BCUHB announcements and email to all Ward managers.</p> <p>The SLT undertakes a 3 monthly self-assessment of 40 standards related to Safe Clean Care and progress against assurance standards reviewed.</p> <p>The SLT provides an exception report on IPC to the monthly Divisional IPC meeting. Key metrics requiring improvement and renewed focus is on ensuring daily Covid-19 and hand hygiene audits are consistently undertaken and mandatory IPC training Level 1 and 2 is increased throughout the unit.</p> <p>Action</p>	<p>HON</p> <p>HOP</p> <p>DOP</p>	<p>31/10/21</p> <p>30/09/21</p> <p>Completed</p>

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
<p>Security Guards were observed coming onto the unit from another area of the hospital. They were not wearing their masks correctly and went straight onto a ward without complying with hand hygiene protocols.</p>		25. To achieve required improvements aligned to IPC key metrics.	HOP	15/09/21
		26. To review the Covid-19 Action Card and update aligned to the MH&LD Winter Plan.		
		27. To liaise with the IPC Associate Director in relation to any additional IPC advice, guidance or support to the unit.	HOP/HON	17/09/21
		28. Recirculate memo, via Safety Huddle, regarding completion of the Visiting Record Checklist and Visitors' Log.		
		29. All staff to be reminded when receiving visitors into units, that BCUHB IPC guidance is followed at all times, inclusive of hand hygiene.		
		<p>Current position - The issues aligned to lack of hand hygiene protocols and inappropriate wearing of face masks by the security guards has been escalated to the</p>		

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
Staff were being utilised from other areas of the hospital and across the health board to assist with staffing issues on Hergest unit. It was unclear what procedures were in place to prevent any potential transmission of infection.		appropriate BCUHB department. A Datix has been raised and a 'Make It Safe+' is being progressed aligned to this incident. This will identify any additional learning from this episode.	ACSM	17/09/21
			HOP/HON	21/09/21
		<p>]Action</p> <p>30. PTR process to be fully implemented to enable the MIS+ to be completed.</p> <p>31. Scrutiny of MIS+ investigation to identify any learning from this episode by the West SLT.</p> <p>Current position regarding Staff utilised from other areas</p> <p>Any staff who are redeployed across the Division are deployed in accordance with the health board staffing escalation policy and the latest IPC Covid-19 guidance.</p>	HOP	15/10/21

Improvement needed	Regulation / Standard	Service action	Responsible officer	Timescale
		32. Local SLT to have monitoring and review arrangements in place to ensure the IPC Covid-19 guidance is consistently implemented aligned to staff deployment.		
Quality of management and leadership				
No Immediate concerns identified at this time.				

Service / health board Representative:

Name (print):

Carole Evanson

Role:

MH&LD Director of Operations (interim)

Date:

17/09/2021

Appendix C – Improvement plan

Service: Betsi Cadwaladr University Health Board

Ward/unit(s): Hergest Unit

Date of inspection: 6 – 8 & 20 – 22 September 2021

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of the patient experience				
The health board must ensure that the bath is fixed on Cynan Ward.	4.1 Dignified Care	<p>The bath within Cynan was LOLER inspected and Planned Maintenance checked by Caretech on 11/08/21, with no faults noted. Additional check of bath on 21/09/21 during HIW Inspection, and no faults noted.</p> <p>Review the need for this bath in the ward area, and progress with informed decision.</p>	Head of Operations	15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that the blocked toilet on Aneurin Ward is fixed.	4.1 Dignified Care	Toilet was unblocked during the HIW visit	Head of Operations	Completed
The health board must ensure that the bathrooms are not used as storage areas.	4.1 Dignified Care	Site review to be completed to ensure appropriate storage facilities identified for any mobility aids and equipment on site	Head of Operations	30/11/21
The health board must ensure that the Section 136 suite remains open and there are sufficient staff available to cover admissions.	5.1 Timely access	<p>To ensure effective E-roster planning, aligned to KPI's.</p> <p>To ensure efficient planning to known absences through allocation of duties locally, bank, overtime or agency where required.</p> <p>To continue with a daily review of staffing through the Acute Care Meetings and Safety Huddles to support resolution of any staffing issues locally.</p> <p>To ensure any outstanding staffing issues are escalated into the Divisional Huddle for resolution/mitigation</p> <p>For out of hours, escalation to MH&LD Divisional Bronze/Silver on call for resolution/mitigation</p>	Head of Operations/ Head of Nursing	Completed and reviewed daily

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there is appropriate privacy measure for the toilet located in the Section 136 Suite.	5.1 Timely access	Ensure dignity screens are in place at all times to enable appropriate privacy	Head of Operations	Completed
The health board must ensure that a pathway is developed in the health board for older adult care.	5.1 Timely access	OPMH Pathway: Divisional meetings have commenced with clear terms of reference. Second meeting held 26/10/21.	OPMH Pathway Lead	Completed and monthly meetings
		Options appraisal to be completed based on the qualitative baseline data for the area.	OPMH Pathway Lead	30/11/2021
		Project plan to be developed and progressed via monthly OPMH meetings.	Head of transformation	30/12/2021
		OPMH service model development to be identified and progressed through the Clinical Strategy Group.	OPMH Pathway Lead	30/06/2022
The health board must ensure that capacity assessments are completed and recorded in patient records.	6.2 Peoples rights	Bulletin to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/21 15/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/21
		Further development of the patient notes audit checklist to ensure inclusion of all necessary standards, including capacity assessments.	Head of Nursing	30/11/21
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation.	Head of Nursing	30/11/21
		Copies of the bulletin are displayed on ward notice boards and discussed at handovers.	Head of Operations	16/11/21
The health board must put a system in place for patient meetings with ward staff.	6.3 Listening and Learning from feedback	Develop fortnightly group meetings between patients and staff, using the model developed by Rehab Services.	Head of Operations	30/11/21
Delivery of safe and effective care				
The health board must ensure that staff confirm the identity of visitors prior to allowing access on to the ward.	2.1 Managing risk and promoting health and safety	Email circulated to all service areas on 14/09/21 reaffirming guidance for any visitors to units.	Head of Operations	Completed 14/09/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		<p>Review Visitor Logs and Visitor Record Checklist to ensure correct completion weekly.</p> <p>Reaffirm visitor process and procedures in MH&LD Staff Briefing.</p> <p>Include email in staff handover document.</p>		<p>Completed and ongoing</p> <p>15/11/21</p> <p>15/11/21</p>
The health board must ensure that sticky tape residue marks where items had been stuck to doors and windows is removed.	2.1 Managing risk and promoting health and safety	Domestic supervisors emailed on 27/10/21 to support full review of all doors and windows, to ensure rectified.	Head of Operations	15/11/21
The health board must ensure that the plaster flaking on walls both sides of the garden entrance door to Cynan Ward is resolved.	2.1 Managing risk and promoting health and safety	<p>Identified during estates senior walk about on 21/09/2021 and is included in full estates plan for the Hergest site, which is currently going via tendering processes.</p> <p>Continued progress to be monitored via Local Area Estates monthly meetings.</p>	Head of Operations	30/11/21
The health board must ensure the plaster flaking and dampness near the external door to the 136 suite is resolved.	2.1 Managing risk and promoting health and safety	Identified during estates senior walk about on 21/09/21 and is included in full estates plan for the Hergest site, which is currently going via tendering processes.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continued progress to be monitored via Local Area Estates monthly meetings.		
The health board must ensure that the cluttered storage cupboards are organised.	2.1 Managing risk and promoting health and safety	<p>Full site mapping of all identified storage cupboards that require organising</p> <p>Delegate task of organising cupboards to named member of staff.</p> <p>Ensure spot checks of storage cupboards are incorporated in monthly Matron unit walkabout.</p>	Head of Operations	<p>15/11/21</p> <p>22/11/21</p> <p>30/11/21</p>
The health board must ensure that the hot water tap is fixed on Aneurin Ward.	2.1 Managing risk and promoting health and safety	Fixed on 24/09/21.	Head of Operations	Completed
The health board must ensure that the patient bathrooms are not used as storage areas.	2.1 Managing risk and promoting health and safety	<p>The disabled bathrooms are currently not in use where items are stored.</p> <p>Assess the alternative storage requirement needs on a site wide basis.</p> <p>Identify alternative storage and move all items that need to be stored on site.</p>	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that risk assessments are undertaken for all individuals on a ward when a high/low profiling bed is being used.	2.1 Managing risk and promoting health and safety	Ensure the risk assessment and Bed Escalation Decision Making Guide is completed for every admission to identify the most appropriate bed.	Head of Nursing	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards, risk assessments for high/low profiling beds.		30/10/21
		Routine checks to be added to the manager's weekly ward round and monthly Clinical Site Manager walkabout		30/10/21
The health board must ensure that there are regular environmental audits to identify any unreported damaged areas.	2.1 Managing risk and promoting health and safety	Environmental Audits to be completed monthly by the Clinical Site Manager, or designated manager in his/her absence.	Head of Operations	30/12/21
		The Audit outcome will be an Agenda item in the monthly Quality, Safety and Experience (QSE) meeting to ensure actions have been taken, and monitoring and review arrangements are in place.	Head of Nursing	30/12/21
			Head of Nursing	30/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Continuation of the Credits for Cleaning bi monthly audits take place and feed into QSE meetings. To introduce quarterly senior management Hergest walk about together with Estates.	Head of Operations	30/12/21
The health board should ensure that there is representation from ward staff at meetings.	2.1 Managing risk and promoting health and safety	Review the Terms of Reference for core meeting to ensure there is appropriate representation from ward staff.	Head of Nursing	15/11/2021
The health board must ensure that all staff check visitor's compliance with COVID-19 procedures.	2.4 Infection Prevention and Control (IPC) and Decontamination	Email circulated to all areas on 14/09/21 reaffirming guidance for any visitors to the units. Reaffirm visitor process and procedures in MH&LD Staff Briefing. Delegate task of Notice Board responsibility to named member of staff, to ensure regular updates, refresh documents and items are clearly visible	Head of Operations	Completed 15/11/21 15/11/21
The health board must ensure that the isolation suite has suitable storage for PPE.	2.4 Infection Prevention and	Full review of this area has been completed with Infection Prevention	Head of Operations	Completed

Improvement needed	Standard	Service action	Responsible officer	Timescale
	Control (IPC) and Decontamination	Lead, Acute Care Site manager, Head of Nursing and Head of Operations. Specific storage containers fixed to walls and in designated areas within this environment		
The health board must ensure that HIW are provided with details of improvements made to the isolation suite.	2.4 Infection Prevention and Control (IPC) and Decontamination	As noted in 2.4. Additionally, designated doffing and donning area is now available. Sink for effective hand hygiene is now in place. Clear signage visible to ensure staff compliance at all times.	Head of Operations	Completed
The health board must ensure that staff record fridge and clinical room temperatures.	2.6 Medicines Management	Communication to be circulated to all inpatient staff in relation to ensuring that staff record fridge and clinical room temperatures. Communication to be discussed during staff handovers. Nominated ward lead for the day to be allocated the responsibility that daily	Head of Nursing	22/11/21 22/11/21 Completed 31/10/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		<p>fridge audits are completed and discussed at all handovers.</p> <p>Acute Care site Manager to routinely undertake spot checks to ensure implementation</p> <p>Continued support from pharmacy leads to ensure compliance during their weekly ward visits.</p>		<p>Completed</p> <p>Completed</p>
The health board must ensure that any fridge or clinic room temperatures outside the required range are addressed.	2.6 Medicines Management	<p>Any fridge or clinic temperatures outside the required range, following the routine checks highlighted above, to be addressed immediately or escalated as required if unable to be resolved.</p> <p>This issue identified during the HIW inspection was resolved at the time, via support from lead pharmacist.</p>	Head of Operations	Completed
The health board must ensure they investigate the raised temperature in the clinical room.	2.6 Medicines Management	Undertake room temperature audit over a month, discuss results with Estates department for informed decision of next steps.	Head of Operations	30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Include clinical room temperature review on the Agenda of local area Estates meeting to ensure action progresses.		
The health board must ensure that dated of opening liquid medications are recorded.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to dating of opened liquid medications. Include spot checking of dates recorded on open medication on weekly ward manager walkabout.	Head of Nursing	05/11/21
The health board must ensure that any allergies are clearly specified on drug charts.	2.6 Medicines Management	Communication circulated to reaffirm Medicines Management policy, including additional communication aligned to allergies.	Head of Nursing	05/11/21
The health board must ensure that staff are aware of the location and content of the medication management policy.	2.6 Medicines Management	Communication circulated to reaffirm the location and content of Medication Management policy.	Head of Nursing	05/11/21
		Ensure location and content of Medication Management policy is included in staff Induction.	Education and training lead	31/03/22

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Ensure the Medication Management policy is continually clearly displayed in all ward areas and clinical rooms.	Clinical Site Manager	05/11/21
The health board must ensure that the unmet needs are evidenced and documented within patient care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of unmet needs.	Head of Operations	15/11/21
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/21
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation.	Head of Nursing	30/11/21
		Copies of correspondence are displayed on ward notice boards and discussed at handovers.	Clinical Site Manager	6/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that observation record sheets are accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of therapeutic, observation and engagement documentation requirements.	Head of Operations	15/11/21
		MH&LD Staff Briefing to also include above correspondence.	Head of Operations	15/11/21
		Further development of patient notes audit checklist to ensure inclusion of all required standards,	Head of Nursing	15/11/21
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/21
		Copies of correspondence to be displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/21
		Review of the current MH&LD Therapeutic, Observation and	Head of Operations	31/12/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Engagement policy and training plan to support implementation.		
The health board must ensure that food and fluid charts are completed in full and accurately recorded.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of food and fluid charts documentation is completed for relevant patients.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that review dates are recorded in care plans.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of care plans.	Head of Nursing	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.		15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards		15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation		30/10/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.		16/10/2021
The health board must ensure that patient records have evidence of physical assessments taking place.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of the risk booklet on admission	Head of Operations	15/11/2021.

Improvement needed	Standard	Service action	Responsible officer	Timescale
		MH&LD Staff Briefing to include above correspondence.	Head Of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021
The health board must ensure that capacity assessments are completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of capacity assessments.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Nursing Clinical Site Manager	30/11/2021 16/11/2021
The health board must ensure that COVID-19 care plans are fully completed.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of Covid 19 care plans. MH&LD Staff Briefing to include above correspondence. Further development of patient notes audit checklist to ensure inclusion of all required standards. Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Operations Head of Operations Head of Nursing Head of Nursing	15/11/2021. 15/11/2021 15/11/2021 30/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Head of Nursing	16/11/2021
The health board must ensure that care co-ordinators are identified and named in patient records.	3.5 Record keeping	Correspondence to be sent to staff reaffirming Good Record Keeping guidance, to include highlighting the importance of accurate completion of details of all professionals involved in patients' care.	Head of Operations	15/11/2021.
		MH&LD Staff Briefing to include above correspondence.	Head of Operations	15/11/2021
		Further development of patient notes audit checklist to ensure inclusion of all required standards.	Head of Nursing	15/11/2021
		Weekly and monthly audits activity to be undertaken by the Ward Manager and the Acute Care Site Manager to ensure consistency of implementation	Head of Nursing	30/11/2021
		Copies of correspondence are displayed on ward notice boards and discussed at staff handovers.	Clinical Site Manager	16/11/2021

Improvement needed	Standard	Service action	Responsible officer	Timescale
Quality of management and leadership				
The health board must ensure that management and ward staff work together to build up confidence and trust.	Governance, Leadership and Accountability	Together with staff identify how confidence and trust can be strengthened.	Head of Operations	31/12/21
		Communicate and engage with staff to listen to and understand how this can be achieved.		16/11/2021
		To review the outcome of the MH&LD Reflect and Learn Survey, currently being undertaken across the Division.		31/12/21
		Increased visibility and accessibility of Senior Leadership Team across the unit.		Completed
		Implement 'You Said, we did' notice boards, and to enable staff to make suggestions install Suggestion boxes across the ward areas.		31/12/21
The health board must ensure that senior management improve communication with staff.	Governance, Leadership and Accountability	Increased presence on the wards by Senior Leadership Team.	Head of Operations	Develop cycle of visits by 30/11/21 30/11/21

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Review and strengthen MH&LD Communication and Engagement plan.	Director of Nursing/Director of Operations.	30/11/21
		Continue with annual MH&LD Staff Briefing cycle of business.	Director of Operations	30/11/21
		Review outcomes of the MH&LD Staff survey themes.	Head of Workforce	30/11/21
		Develop staff focus groups to ascertain preferred communication methods for staff.	Head of Operations	
The health board must ensure that MDT work collaboratively with ward staff.	Governance, Leadership and Accountability	Review current function and Terms of Reference of Weekly MDT meetings, to ensure full engagement and collaboration with all disciplines.	Head of Nursing	16/11/2021
The health board must ensure that a consistent and stable senior management team is maintained.	Governance, Leadership and Accountability	The Division recognises the importance of stable leadership, and are actively progressing through workforce processes to enable the long term	Director of Operations/ Director of Nursing	31/03/2022

Improvement needed	Standard	Service action	Responsible officer	Timescale
		<p>stability of the Senior Leadership team to be affirmed.</p> <p>In the meantime, consistency of interim arrangements will continue.</p>		
The health board must ensure that staff do not work excessive hours.	7.1 Workforce	<p>Memo circulated on 28/10/21 to all MH&LD staff.</p> <p>Memo to be displayed on notice boards and discussed in handovers.</p> <p>To continue with a daily review of any staff working excessive hours through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.</p>	Head of Operations	<p>Completed</p> <p>05/11/21</p> <p>Completed</p>
The health board must ensure that staff have breaks and feel confident leaving the ward for breaks.	7.1 Workforce	<p>Memo circulated on 28/10/21 to all MH&LD staff.</p> <p>Memo to be discussed at staff handovers.</p> <p>Memo to be displayed on ward notice boards.</p>	<p>Head of Operations</p> <p>Clinical Site Manager</p> <p>Clinical Site Manager</p>	<p>Completed</p> <p>15/11/21</p> <p>15/11/21</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
		<p>To continue with a daily review of any staff who are unable to take their breaks through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.</p> <p>Ensure escalation to SLT in hours, or bronze if out of hours, if staff unable to take their breaks.</p>	<p>Head of Operations</p> <p>Head of Operations</p>	<p>Completed</p> <p>Completed</p>
The health board must ensure that there are appropriate areas where staff can take their breaks.	7.1 Workforce	<p>Review of current staff rooms and facilities on site.</p> <p>Continue with the development of Wellness room on site.</p>	Head of Operations	05/11/2021
The health board must ensure that staff rota records are robustly managed and that any changes or amendments to staffing are accurately recorded.	7.1 Workforce	<p>Review of E roster KPI compliance on a weekly basis, to ensure actions taken where compliance it not met.</p> <p>Additional E roster training to be completed in order to ensure all managers are aware of KPI's and guidance.</p>	Head of Nursing	<p>Completed</p> <p>30/11/21</p>

Improvement needed	Standard	Service action	Responsible officer	Timescale
The health board must ensure that there are adequate staffing levels to maintain a safe environment at all times including additional staff to cover observation times.	7.1 Workforce	To continue with a daily review of staffing levels through the Acute Care Meetings and Safety Huddles to support resolution of any issues locally.	Head of Operations/Head of Nursing	Completed daily.
		Staffing establishment review commenced to enable creation of an agreed model, and understanding of staffing requirements to ensure safe delivery of care in all Divisional inpatient settings.	Director of Nursing	30/1/2022
The health board must ensure that mandatory training figures are improved.	7.1 Workforce	Mandatory Training compliance monitored and reviewed weekly at Operational Leadership meeting.	Service Managers	Completed and continue to monitor weekly
		Local Area Performance report provides an in-depth summary of mandatory training for all staff disciplines, discussed and reviewed at the monthly Quality, Operational and Delivery meeting, recommended actions to be implemented as required.	Head of Operations	Completed monthly

Improvement needed	Standard	Service action	Responsible officer	Timescale
		Divisional Mandatory training compliance reviewed at DSLT Finance and Performance meeting, recommended actions to be implemented as required.	Head of Operations	Continue monthly
The health board must ensure that regular team meetings take place for staff.	7.1 Workforce	SLT to work with ward managers to support full implementation of team meetings for all disciplines in their areas	Head of Operations.	15/11/2021

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 (print): **Carole Evanson, MH&LD Director of Operations (Interim)**
Mike Smith, MH&LD Director of Nursing (Interim)

Date: 01/11/2021

Headings	Ref from RCS Report	Recommendation	Actions required	Operational / Clinical	Action by	Owner	Legacy Start Date as per report	Legacy End Date	New / Revised Start Date	New / Revised End Date	Actual End Date	Task Status	If overdue, what are the issues?	Progress update - include reasons in here for revised start or end date, and impact this will have on the overall deliver of the milestone
	RCS Report Recommended Actions													
Pathways	4.1	Requirement for agreed and clear pathways to ensure timely and effective treatment at Hub and Spoke sites	Timely MDT is required at all sites. For spoke sites, this should be led by a spoke based Vascular Consultant making use of on call surgeon if this is not available	Clinical	Soroush Sorabi	Ramesh Balasundaram	01/04/2021	31/05/2021				Complete		A North Wales MDT is held every Friday pm involving all available vascular consultants, interventional radiology and anaesthesia which covers patients from all three areas. In addition a meeting has been established in June 2021 at YGC involving vascular and microbiology to discuss the ongoing care of inpatients. Local MDT are job planned for spoke sites
			Diagnostic and assessment services should be available in a timely manner. CT / MRI / Sonography etc.	Clinical	Kakali Mitra supported by Helen Hughes	Executive Medical Director	01/04/2021	31/05/2021		31/03/2022		In Progress	Regular review of Diagnostics waits. CT / MR compliant but sonography requires investment and recruitment lead time	25th November update - met with Helen Hughes, report being prepared for 26th to update the board on the progress in recovery relating to diagnostic waits. They are now meeting the Welsh Health Board guidance for 2wk wait for Urgent and 8 Wk. for routine for both CT and MR. Sonography is not yet meeting the targets and is not possible until the resource requirements are addressed to provide the staff to scan. Date has been realistically amended from 1 December to 31 March to allow time for both business case approval and recruitment of staff to achieve the desired timescales for sonography waits. All other locum routes etc. have been exhausted. Regular meetings planned to discuss progress to date and radiography are including this on their action plan.
			Repatriation pathway to be completed, signed off and utilised for admission to spoke sites from the hub	Operational	HoNs supported by DGMs and Clinical Leads	Acute Site Directors	01/04/2021	31/05/2021		28/02/2022		In Progress	Further work required with Care of the Elderly team at West	3 December update - recirculated to Rhian Hulse, Keeley Twigg, Lesley Walsh and Ellie Kite for circulation again as been a year since agreement. It was held up at CAG as lack of evidence to support nursing involvement. Nursing clear involvement this time - Deadline for comments 16 December 2021 and then for CAG presentation 27.December update - Feedback from West COTE team - they now don't agree with end of life management sitting within their specialty alone.
	4.1.8		Requirement of a vascular review / escalation and transfer pathway into the hub site	Clinical	Soroush Sorabi supported by Specialty Leads	Medical Directors	21/09/2021	31/10/2021				Complete		See Emergency pathway for spoke site transfers Spoke sites contact VCOW / On call Vascular surgeon to accept and transfer the patient to the Hub site
	4.1.7		Finalisation and sign off for IVDU pathway	Clinical	Vascular Network Manager	Specialty Leads GS / Vascular/Radiology / ED	01/04/2021	30/06/2021		01/12/2021	12/11/2021	Complete		13 December 2021 - for CAG presentation 15 December 2021 Signed off by CAG 15/12/21 - Awaiting Executive sign off
			Day Case Angioplasty pathway finalisation and sign off	Clinical	Soroush Sorabi supported by Specialty Leads	Medical Directors	01/04/2021	30/06/2021				Complete		Approved by CAG and the Executive team Jan 2021 and has been implemented
	1		Clarity on role of the leadership and management in spoke sites, hub site and the vascular network manager.	Operational	DGMs	Acute Site Directors			16/09/2021	24/01/2022		In Progress	Specialty lead commencing 10 January 2021 at the hub providing operational support from each site to allow a wider network view for the specialty	Fortnightly meetings to work look at working more collaboratively across the hub and spoke sites to improve engagement and help to clarify with support from DGMs the expectation across the sites. 16 November update - Site Vascular leads have been 'appointed' Vascular manager is co-ordinating between the 3 sites although awaiting some project support to deliver the plan. A secondee is planned for January 2022 to support day to day operational management and tackle some of the action plan. 1 December update - Band 5 Ast Specialty lead commenced and awaiting specialty lead allocation to allow for substantive and robust comms with spoke sites with escalation to lead manager and vascular network manager accordingly. Vascular specialty at the hub to fall in line with management of other specialties with VNM to oversee the 3 sites and review strategic development when all staff are in place. 10th January will see the arrival of a specialty lead manager who will cover Vascular to provide each site with accountable ops teams with oversight from the vascular network manager
	2		Create and disseminate Primary Care Pathways / guidance in relation to vascular conditions	Clinical	Soroush Sorabi supported by Bethan Jones and Laszlo Papp	Ramesh Balasundaram				31/03/2022		Not yet commenced	Delay in commencing due to available capacity	Soroush and or designated Vascular surgeon to work with Bethan to write guidance for primary care starting 2022
	4.1.5	Management of patients post major arterial vascular surgery Pathway requires final sign off ensuring communication between hub and spoke regarding discharge and follow up is improved	Rehabilitation needs are assessed by the relevant clinical teams prior to discharge and appropriate rehabilitation services are accessed locally wherever possible	Clinical	Soroush Sorabi	Ramesh Balasundaram	22/05/2020	27/01/2021				Complete		Referrals completed in line with required rehabilitation needs. Issues relating to full delivery of this action at the YGC site relate to resource gap in therapies to support timely follow up and some environmental / capacity issues for post operative follow ups. The action itself as described is complete. the timeliness aspect requires review
			All relevant clinical services at hub and spoke sites are aware of the pathway and have robust mechanisms in place to ensure discharge plans are communicated to relevant teams	Operational	Specialty Leads supported by , Vascular Network and DGMs all sites	Acute Site Directors supported by Medical / Nursing Directors	22/05/2020	27/01/2021				Complete		Pathway signed off and communicated as per legacy project plan comments
	4.1.8	Pathways are required to enable non-complex / low risk peripheral vascular interventions to be undertaken (in line with VSGBI guidelines) mainly as day cases at spoke sites	Agreement regarding interventions to be undertaken at Spoke sites	Clinical	Clinical Leads supported by DGMs all sites	Medical Directors	01/04/2021	30/06/2021	25/10/2021	03/12/2021	26/11/2021	Complete		It has been agreed which vascular procedures can be completed at spoke sites in addition to Orthopaedic interventions. Changes have not yet been fully implemented due to ongoing discussion relating to theatre capacity and bed availability. 1. simple fistulas/ PD catheters 2. day case angioplasty 3. minor amputations / debridement 4. VV procedures both open and endovenous 25th November update: Email correspondence with Spoke Site MDs to confirm clarity on the above procedures being carried out routinely at spoke sites. Awaiting confirmation of clarity. 26th November update - Clarification and dissemination of information from Medical Directors at Spoke sites to ensure clarity on what can be completed locally.

			Details for inpatient responsibility for patients requiring admission following general anaesthesia	Clinical	Medical Directors	Nick Lyons	01/04/2021	30/06/2021			28/02/2022	In Progress	Awaiting clarification from MDs	5/10/21 Meeting planned with Medical Directors to agree IPS and accountability and responsibility for Shared care to be disseminated through the medical teams 10 November 2021 - The Medical Director who wanted to progress was sick and then on AL, another was unavailable due to return flights. Meeting delayed. 16 November update - dialogue is taking place amongst the Medical Directors. 3 December update - Non-complex / low risk procedures outlined to medical directors and disseminated through operational teams for awareness - Awaiting feedback in relation to a plan for patients requiring an overnight stay post general anaesthesia. 30 December 2021 = West have signed off, General Surgery at East in discussion with MD
Diabetic and Vascular patient management	4.1.6		Agree assessment protocols from Diabetology team for the Non arterial Diabetic Foot Pathway	Clinical	Diabetology leads	Medical Directors	01/04/2021	30/06/2021		16/11/2021	10/11/2021	Complete		5/10/21 Draft of Diabetic Foot Pathway (DFP) circulating for sign off by BCU DF meeting. Require a single Pathway with individual sites having a brief document with their specific caveats. Diabetology input in relation to assessment is in keeping with NICE guidance and agreed. Remaining aspects of the pathway yet to be signed off 10 November update - from a diabetology perspective we have agreement from East (Anthony Dixon, Centre Gayatri Sreemantula and Karen Mottart on behalf of West)
			Identify a diabetic foot / foot salvage lead within the vascular team to support all sites and support spoke teams to standardise care and pathways	Clinical	Soroush Sorabi	Ramesh Balasundaram	01/04/2021	30/06/2021		08/11/2021	21/10/2021	Complete		Soroush Sorabi is the Diabetic foot lead across BCU with along with spoke site leads Faisal Shaikh and Laszlo Papp undertaking this role at YG and WMH.
			Agree assessment protocols from Diabetology team for the Non arterial Diabetic Foot Pathway	Clinical	Medical Directors supported by DGMS / Vascular network manager	Executive Medical Director	01/04/2021	30/06/2021		01/12/2021	19/11/2021	Complete		MDT arrangements in place albeit some completed outside of formal job plans however are completed during other allocated spoke activity. There is work to be done to ensure that all disciplines are in attendance at all sites. Progress at spoke sites is further ahead than Centre but the focus is now in bringing Centre up to speed with consultant appointment / locum support / planned Middle grade remodelling. Protocols however agreed from a diabetic input perspective
			Patients at spoke sites diagnosed with diabetic foot sepsis without arterial compromise should remain at spoke sites if possible. If not possible, a pathway is required for urgent transfer to the hub.	Clinical	Medical Directors supported by and Specialty Leads / DGMS	Executive Medical Director	01/04/2021	30/06/2021		31/03/2022		In Progress	Awaiting visit to centre of excellence January 2022 to view process for informing the final section of the emergency pathway. Aim March 2022 sign off	13 December 2021 - Diabetic Foot Pathway - Signed off in entirety from West, Signed off by all aside from Orthopaedics for East and Centre. Awaiting Ortho 'pathway' to be amended by East Ortho team as discussed with Nick Lyons 30 December -Centre specialty lead wishing to review Blackburn's pathway and practice prior to fully signing off the pathway and agreeing to required resources.
			Clear arrangements are required at spoke sites, including the specialty that the patient is being admitted under to allow for input from vascular if required	Operational	Medical Directors	Executive Medical Director	01/04/2021	30/06/2021		01/12/2021	26/11/2021	Complete		Action slightly amended - no vascular beds at spoke sites which means that all patient requiring vascular procedures not able to be completed as day case will transfer to the hub. Those patients that fit the criteria for day case management will remain under their primary care provider allowing for vascular input as needed. Local vascular teams to co-ordinate this. Middle grade tiers are present at each spoke site to support this in line with interventions that can be completed at spoke sites.
	4.2.15	Develop Non-arterial Diabetic Foot Pathway should be finalised urgently with involvement of all relevant teams	Review the resource required for a diabetology consultant to Spoke sites (including non-consultant grade support) to ensure that capacity meets the demand and enables ward beds to be covered by a Diabetologist and play a key role in vascular care	Operational	DGMS YG / WMH	Acute Site Director YG / WMH	01/04/2021	30/06/2021		01/12/2021		Complete		Awaiting capacity gap information. Est / West DFP groups have been asked to provide a rough estimate in the first instance and demand information has been shared to support their decision making. Centre to be asked 12/10/21 meeting. 10th November update- Information from BCU has been provided for the diabetology requirements to deliver the pathway. This needs pulling into a business case. SM to action. 25th November update - BCU resource requirements for DFP Diabetes confirmed - awaiting West final version 26th November update - Confirmation for each site requirements for diabetology. Specialties to progress with submission to IMTP. All informed via email 26/11/21
			Review the resource for Orthopaedics required to support the implementation of the DFP	Operational	Specialty leads supported by DGMS	Medical Directors supported by Acute Site Directors	01/04/2021	30/06/2021		28/02/2022		In Progress	Awaiting visit to centre of excellence January 2022 to view process for informing the final section of the emergency pathway.	13 December 2021 - Awaiting Centre confirmation of resource requirement. Escalated to Balasundaram Ramesh 30 December - Centre specialty lead wishing to review Blackburn's pathway and practice prior to fully signing off the pathway and agreeing to required resources.
			Review of resource for Podiatry at spoke sites to support the pathway following sign off	Operational	Podiatry Leads	Head of Therapies	01/04/2021	30/06/2021		01/12/2021	19/11/2021	Complete		5/10/21 Gap analysis completed but needs some additional detail for the business case. SM meeting with podiatry teams to collate 10 November update - SBAR sent to Acute Site Director for Centre for Centre DFP podiatry and therapies requirement. Awaiting updated finance for business case for Centre for inpatient therapies. 25 November update - received podiatry requirements Pan BCU Received East and West podiatry departments.
			Review of Specialist Nursing support to realise the diabetic Pathway	Operational	HoNs	Directors of Nursing supported by DGMS	01/04/2021	30/06/2021		01/12/2021	26/11/2021	Complete		Awaiting capacity gap information Wd 3 have completed with a view to increasing bed base to 21 with a high observation area but CNS / ANP resource requires review across sites inclusive of succession planning to futureproof the service 25 November update - To aim to mirror process at Centre across spokes (1 ANP clinically focused and 1 CNS wound focussed) to make vascular presence more robust. Requirements to deliver included on plan.
			Diabetic Foot clinics to be held jointly with vascular surgery and podiatry at all sites	Clinical	Soroush Sorabi	Medical Directors	01./04/21			31/03/2022		In Progress	Awaiting visit to centre of excellence January 2022 to view process for informing the final section of the emergency pathway.	13 December update - Some contention about whether they should be weekly / fortnightly MDT sessions instead of joint. This may indeed be aspirational for the time being due to room constraints and need to keep momentum of joint clinics running. In place East and West. Not in Centre as yet. 30 December 2021 - No responses for additional sessions dates from vascular or orthopaedics. Pending review on 11 January of Blackburn service to commit to implementing a soft launch with the joint / MDT clinics
			Consideration of appointment for a network wide podiatric surgeon / orthopaedic surgeon with special interest in vascular to support the foot salvage service across all sites	Clinical	Medical Directors supported by the Therapy Director	Executive Medical Director	01/04/2021	30/06/2021				Not yet commenced	Escalated to Medical Directors	Discussed with Gareth Evans 8/10/21 No current progress on this consideration to date. May depend on the outcomes of Orthopaedic surgeon discussions in the first instance at this stage. 25 November update - Unsure that this requirement is necessary - to discuss at Vascular oversight group 10/12/21 30 30 December - communicated to Medical Directors for review as not yet progressed with no sign of requirement for the post unless allocating to existing staff member

Governance	4.1.9	Improvements are required in line with improving the effectiveness of clinical governance	Improve collaborative sign off for actions and learning from incidents. TOR for governance meetings require a review in addition those required to attend	Operational	Hans Desmorowitz supported by the Vascular Network Manager	Soroush Sorabi	01/04/2021	28/05/2021		17/12/2021		Complete	Not discussed 9/11 Sent out for comments and amended - resent 13/12/21	Sent TOR for sign off at governance meeting - meeting membership reviewed SM 27/10/21 16 November update -TOR on the agenda for the CG meeting - reminder email sent to all to review and agree - to be reviewed in full 10/12/21. 13 December update: Comments reviewed for TOR - require re-submission to the group for approval. 17 December update - Nil comments received in specified time frame
			Consider appointment of an external chair for governance meetings	Clinical	Conrad Wareham	Executive Medical Director	01/04/2021	29/05/2021		01/01/2022	27/11/2021	Complete		Gary Francis had previously been overseeing aspects of the governance meetings and has since left the organisation. Awaiting update on his successor to continue with progress. 25th November update - Conrad Wareham has been appointed as interim Medical Director BCU - will oversee and support governance processes and structure.
			Audit of processes to ensure that agreed changes to clinical practice arising from shared learning are effected	Clinical	Hans Desmorowitz	Soroush Sorabi supported by Interim Deputy Exec Medical Director				30/12/2021	30/04/2022	In Progress		Collation of learning to be completed and made reference to for governance meetings and datix events in light of similar incidents.
			Clarify the requirements for the process of root cause analysis for all major amputations	Clinical	Hans Desmorowitz	Soroush Sorabi	01/04/2021	31/05/2021	31/10/2021	18/01/2022		In progress	Not presented 10.12 deferred to 18/1/22 meeting	10 November update - discussed at the clinical governance meeting on 9 November - Aw SS response 25th November update: RCA proforma to be presented at the next governance meeting 10/12/21 13 December update - not completed as yet - deferred to January 18th CG meeting. Requested that the proforma be shared prior to presentation for review
			Admin / governance resource required to support the process in line with organisational standards	Operational	Vascular Network manager	DGM Surgery YGC				01/09/2021	01/12/2021	10/12/2021	Complete	Additional resource is required as we currently have Consultants undertaking activity not in keeping with efficiency. Band 5 has been appointed to aid with rota management and will support the governance recording of actions / outcomes and assist with feeding back to the team. 25th November update - Band 5 starting in post 29/11/21 and will commence support from 10 December governance meeting. Band 2 NVR data entry role added into business case to support from that angle - recruitment time required post business case approval.
	4.2.13	Improve effectiveness of M &M meetings enabling comprehensive MDT discussion and shared learning	Timing of meetings to enable anaesthetic attendance	Operational	Vicky Hughes supported by Vascular network manager	Soroush Sorabi	01/04/2021	01/06/2021					Complete	Anaesthetic Consultant is invited and attend this meeting along with the MDT. Membership review required to separate M&M from true governance meeting to improve attendance and quality. Joint anaesthetic and Vascular M and M time available - next date 10 December 2021. 1 December update - Anaesthetic joint meetings to be held 3-4 monthly to discuss relevant Mortality cases. Vicky Hughes to Liaise with Esther to arrange. Joint meeting 10/12/21
			Audit to ensure that there is a robust process to discussion of all mortality and morbidity and carry forward of discussion to next meeting as needed	Clinical	Soroush Sorabi	Balasundaram Ramesh				30/12/2021	30/04/2022		In progress	Review of cases discussed and cases pending discussion prior to and following each CG meeting
			A robust system required to ensure discussion of all cases, issues to carry forward to next meeting if required. Robust recording and sharing of agreed actions	Clinical	Soroush Sorabi	Balasundaram Ramesh	01/04/2021	02/06/2021		18/12/2021			Complete	Awaiting completion of the action log update - delay due to minutes from the meeting not complete Further work is required to formulate robust methods of capturing and sharing the information and the methodology of doing so. Sally Morris to review with Governance lead before 9 November meeting. 31/10/21 M&M reviews in place, need to review agreement and sharing of learning / actions 16 November update - may need a whole M and M and audit day to clear the backlog 25 November update - reviewed all outstanding cases for discussion - 'backlog' will be clear as of 10 December 2021 CG meeting. 3 December update - Robust system in place. Data exported from BI mortality tool and cross referenced with those previously discussed and list generated to all consultants to prepare for meeting. Improvement for actions and tracking / chasing from new Band 5 required to improve shared learning timely for all. 18 December - delay in signing off as complete as first action log to be completed post CG meeting to provide a robust framework with clear responsibility moving forward
Patient Flow	4.1.2	Review of vascular bed capacity and nursing resource. This section also relates to reduction of cancellations on the day due to bed / ITU / HDU availability	All vascular patients via elective / emergency / transfer from spoke should ideally be placed directly into a vascular bed. If this is not possible, robust plans for reviews must be in place.	Operational	Site Manager	Site Director	01/04/2021	30/06/2021		01//03/2022			Complete	 25 November update - Informed that from a site perspective the move outlined above is not a priority for the time being. VCOW and on call model allows for 'safari ward round'. Need to revisit the responsibilities for the VCOW to ensure robust process is clear to all. The modelling for MG cover across BCU allows for all ward reviews inclusive of outliers. Awaiting business case and time will be required for recruitment following this so envisaged Feb / March 2022 for the introduction of the model assuming recruitment is successful
			Admission and transfer pathways to be developed to ensure that patients are safely and appropriately placed and that any delay in transfer has clear non-surgical optimisation in place prior to transfer	Operational	HoN supported by DGMs	Acute Site Directors				16/09/2021	31/12/2021		Complete	Emergency pathway in place, repatriation pathway covered in action 4.1 under pathways above. Outstanding is finalised version of transfer into ward 3 pathway which relates to the local management of vascular patients
	3		Review theatre capacity and ensure all pre-covid lists are returned	Operational	Elaine Hodgson supported by Theatre Manager	Neil Rogers				01/11/2021			Not yet commenced	Covid 4th wave - currently on hold Alternate Monday all day case list removed during covid 25th November update - issues with theatre staffing prioritising lists in place due to staffing.

Theatres	4	More effective use of the Hybrid Theatre	Achieve dedicated Renal Access Theatre lists across BCU	Operational	Elaine Hodgson supported by Vascular Network manager	Neil Rogers			01/11/2021	31/01/2022		Complete		10 November update -East and West have a dedicated session per month with all patient allocated an accurate P status and booked accordingly ahead of any other non-urgent day surgery cases. Unable to complete this currently at Centre as no day case access - highlighted to DGM for Surgery 25 November update - YGC day surgery list as mentioned in above action would be the dedicated renal access list but having to utilise theatre L capacity 30 December - Renal cases are prioritised at the start of the lists to improve start times with lists containing patients requiring ITU beds. Until the Alternate Monday day case lists are returned this is the dedicated theatre time for renal access.
	5		Increase access to Interventional Radiology sessions - Lack of interventional radiography (IR) sessions making theatre allocation more difficult into appropriate session.	Clinical	Helen Hughes	Executive Medical Director			10/12/2021	01/06/2022		In progress		3 year plan for radiology to support recruitment to this specialist discipline. IR radiographer leaving January 22 seeing depleted IR sessions available.
	6		Require increased access to emergency theatres to prevent cancellations of elective cases	Operational	Elaine Hodgson supported by Sally Morris	Neil Rogers			10/12/2021			In progress	Covid 4th wave - theatre staff issue	Vascular emergency cases can be lengthy and it is not ideal for them to make use of the general CEPOD list for this reason. Additional capacity required for emergency sessions 30 December 2021 -
	7		Robust method required to allocate patients onto theatre lists required	Operational	Surgical Ops team supported by Vascular network manager	Neil Rogers			10/12/2021	31/01/2022		Complete		Meeting planned for 16th December as preliminary discussion as to how operational team can take over the bulk of the allocation using MDT for sign off. 30 December - sign off for proposed operational management of theatre planning with clinical input to aid emergency case placement. Implementation planned by 31/1/22
	4.1.3		Commence lists on time using 'golden patient model'.	Clinical	Theatre Manager supported by Critical Care Lead YGC	Soroush Sorabi supported by Elaine Hodgson	01/04/2021	28/05/2021	01/12/2021	31/01/2022		In Progress	Planned to utilise the first theatre slot for renal access and more minor cases where appropriate and surgeon skill allows	Implementation of a golden patient for use of the hybrid theatre may require the listing of fistulas / minor cases etc. that do not require IR support. This is mostly due to lack of ITU bed availability or decisions to proceed with theatre being delayed pending ITU approval to proceed. Vascular and Intensivist CDs to discuss a way forward in expediting decisions. Theatre booking being taken over by secretarial and operational team commencing 20/12/21 - some cases cannot be completed by all team members which can mean that not all theatre days can commence with smaller golden patients and rely on the larger cases being delayed due to level 2/3 bed availability 13 December update - invite for vascular anaesthetist / CD for vascular and theatre manager to discuss 30 December - Golden patient model not fully operational currently however planning for renal access and minor cases to be scheduled on days with patients requiring ITU to make best use of theatre time and less likely for late starts to lower complexity - to be fully embedded once operational management of booking lists by 31/1/22
			Reduce vacant sessions through backfill for surgeons	Operational	Vascular Network Manager supported by DGM Surgery	DGM Surgery YGC	01/04/2021	28/05/2021		01/03/2022	26/11/2021	Complete	Human resource issue for cover	Locum consultant starting 4/10/21 and 1/11/21 to cover a gaps in funded consultants, 1 is additional to numbers to aid picking up lost activity' due to VCOW / SOD activity to aid increased capacity at spoke sites. Prospective cover in place for SOD. 16 November update - this is in place for spoke sites with locum backfill. Not an issues at YGC as there are no day case lists and all Hybrid theatre days have an allocated Surgeon of the Day Action to remain open awaiting substantive appointments 25 November update - as far as OPD sessions go - the modelling for MGs allows for ANP / Middle Grade / Consultant streams to reduce the loss of activity in relation to on call activity. RISK currently lack of physical space does not allow for this to occur. As far as theatre is concerned SOD is prospectively covered and resource is currently in place to support this.
		Anaesthetic involvement in Friday theatre meetings to reduce those cancellations relating to anaesthetic concerns	Clinical	Anaesthetic CD supported by Soroush Sorabi	Balasundaram Ramesh	01/04/2021	28/05/2021				Complete		A North Wales MDT is held every Friday pm involving all available vascular consultants, interventional radiology and anaesthesia which covers patients from all three areas. In addition a meeting has been established in June 2021 at YGC involving vascular and microbiology to discuss the ongoing care of inpatients.	
Spoke Vascular presence	4.1.4	Vascular presence at Spoke Sites	Consultant review of all vascular patients within 24 hours (48 hours recommended by Vascular society guidance)	Clinical	Soroush Sorabi	Executive Medical Director	01/04/2021	30/06/2021	01/10/2021	31/01/2022		Complete		Locum consultants will cover planned activity that is dropped due to VCOW / SOD or Leave in the interim. Need to also factor in MG cover for spoke sites to support sustainably. This must be rotational to aid the roles being attractive as spoke site activity perhaps not exciting enough to attract on its' own. 5 days coverage at Spoke sites means that the weekend may extend to 48 hours by exception with out Middle grade on call cover. VCOW / on call provides virtual review with a pathway in place for transfer of patients into the hub as needed.
			Spoke site consultant vascular surgeons should be accessible to Diabetology, Orthopaedics, General Surgery and Endocrinology etc. Availability and means of access also need to be clear to all	Operational	Vascular Network Manager supported by/ DGMs	Acute Site Directors	01/04/2021	30/06/2021			18/12/2021	Complete		Spoke site surgeons are have a rota which is shared across all site with relevant specialty groups. The rota includes allocation of surgeons, sites, and contact details. Aim for Health roster to be live soon to aid a live rota version visible to all who need. Awaiting support form health roster team to make live 25 November update - Middle grade ' modelling' provides 8-5 cover for Spoke sites weekdays to increase vascular presence on a rotational basis. Assuming business case approval, will require recruitment time, to consider February / March realisation assuming recruitment successful. Switchboard have all consultant mobile numbers
			Support is required to improve and facilitate communication and team working across hub and spoke sites to reflect a network approach	Operational	Vascular Network supported by DGM Surgery	Soroush Sorabi	01/04/2021	30/06/2021		28/11/2021	25/11/2021	Complete		The rota has been streamlined to be more clear where each consultant is based and their schedule. Fortnightly meetings in place with Ops across BCU and rota co-ordinator and renal and vascular nursing to iron out cover / capacity issues. Good site lead approaches to managing spoke site patient care and communicating back to the hub as needed. 25 November update - need to communicate to Medical Directors clear route for escalation if issues are encountered in contacting the spoke consultants - complete. Weekly meetings held between spoke and hub Vascular specialist nurses. Collaborative working in place currently to be further supported by a pending associate and specialty lead for surgery at the hub site to ensure resilience in the communication between site
			Regular Vascular Nursing staff meetings across the network	Clinical	Vascular nurses all sites	HoN YGC	01/04/2021	30/06/2021		07/10/2021	07/10/2021	Complete		The CNS and ANP both have weekly meetings with spoke sites and are also joining the operational / renal / vascular nursing meetings fortnightly currently. There is some practice to be shared in line with nurse led clinics and this forum will support this venture
			Audit via Datix the failure to review patients within 24-48 hours	Clinical	Soroush Sorabi	Balasundaram Ramesh			30/12/2021	30/04/2022		In progress		
	8	Full capacity and demand exercise requires completion across all sites.	Operational	Vascular Network manager supported by DGM Surgery YGC and Soroush Sorabi	Medical Directors	01/04/2021	30/06/2021		31/01/2022		In progress	Pending BCUHB Demand data and 1st draft capacity by due date	All sites are covered with locum backfill for shortfalls in the short term. 24/10/21 Recruitment of additional consultant to cover spoke site will alter the current working pattern for surgeons based at the spoke site 16 November update - requested demand data from informatics - work will shortly commence to review the current capacity and the potential capacity with recruitment and MG cover 25 November update - Capacity work has commenced	

	4.2.17		Gap analysis of Junior / middle grade and Consultant vascular staff to be included in BCU pan business case. Additional Deanery and non-training grade vascular surgeons required to allow for learning opportunities at spoke sites and to reduce reliance on general surgery trainees	Clinical	Soroush Sorabi supported by Vascular network manager and DMG Surgery YGC	Medical Directors	01/04/2021	30/06/2021		31/01/2022		In progress	1st draft capacity by due date	16 November update - Middle grade rotation inclusive of long day on call, weekend on call and spoke site rotation is underway. Supported by Medical workforce, a rolling job plan has been created to identify the number of MGs, the PA allocation and therefore the salary can be reviewed on this basis. Funding approval will be required and lead time for recruitment and start dates. 1 PA has been factored into the establishment requirements for ward and junior Dr support.
Audit	4.2.14	6 Audits identified by vascular T&F group to be undertaken using national vascular registry (NVR) data should be progressed as part of assessment, evaluation and shared learning	<p>Audits on the following for completion:</p> <p>* Same Day discharge following endovascular intervention (FS) Complete</p> <p>* Timeframes for lower limb bypass or endovascular revascularisation procedure for patients admitted with CLI as emergency (AR) Awaiting</p> <p>* Below, through and above knee amputations since centralisaition (AR) Completed</p> <p>* Carotid endarterectomy - time from symptoms to referral, referral to surgery and outcomes (RF) Awaiting</p> <p>* AAA timelines for referral to surgery open & EVAR and outcomes (LP) Deferred to Jan 22</p> <p>* Complex aneurysm repairs EVAR / Open and outcomes (SS) Awaiting</p> <p>* Conversion of below knee amputation to through and above knee (AR) Completed</p>	Clinical	Soroush Sorabi	Executive Medical Director	01/04/2021	30/06/2021		18/01/2021		In progress	Annual Leave prevented presentation of all outstanding audits at December meeting	<p>Awaiting details on the outstanding audit subjects. New Audit lead appointed given Mr Taha's leave. Faisal Shaikh now leading.</p> <p>15/10/21 Same Day Discharge following endovascular intervention - complete / presented</p> <p>24/10/21 - Update from Soroush 4/7 completed and potential further 2 awaiting presentation, awaiting confirmation from audit leads</p> <p>10 November update - 3 audits outstanding completion / presentation - aim to be presented 10/12/21</p> <p>13 December update - 4 audits to be presented at January 18th 2022. Need to extend meeting from half to full day to accommodate.</p>
Additional Recommendations	4.3.20	Additional Recommendations	Consider including Vascular surgical trainees in the vascular on call to enable exposure to more complex procedures	Clinical	Soroush Sorabi	Balasundaram Ramesh	01/04/2021	30/06/2021			30/12/2021	Complete		Middle grade / trainee on call as on call bleep holder 9-5pm. Service looking to extend out to either long day or 24/7 cover of which trainees can be involved.
			Consider guidelines for tenure length for leadership / management roles to facilitate rotation and support the potential for new ideas and leadership styles	Clinical	Medical Directors	Nick Lyons	01/04/2021	30/06/2021				Complete		This consideration is in the process of being reviewed by the Executive Medical Director in line with what is deemed best for the services.
			Develop an action plan to maintain stability and attract further clinicians given the relatively rapid turnover of vascular surgeons within the service	Clinical	Soroush Sorabi	Ramesh Balasundaram	01/04/2021	30/06/2021				Not yet commenced		This has yet to be reviewed
Communication	9	Completion of Comms section on intranet	The dedicated vascular services page on our website is under development to include a patient stories section, a 'meet the team' component and pictures and video content to demonstrate the high quality facilities and equipment available and is expected to be finalised by the end of November.	Operational	Jez Hemmings	Neil Rogers	01/04/2021	30/06/2021		01/03/2022		In progress	Risk to delivery by due date On hold pending report from notes review	Work is currently being undertaken to migrate the current intranet platform to a new one - no additions will be made until this work is completed with a potential start date for early next year.
		Development of Communications plan	To support the North Wales vascular service and highlight the progress being made, a communications plan is under development and will be reviewed by the Vascular Steering Group.	Operational	Jez Hemmings	Neil Rogers	01/04/2021	30/06/2021		01/03/2022		In progress	Risk to delivery by due date On hold pending report from notes review	Further information required from the clinicians to complete the works for comms to share. Progress to date has been filming in the hybrid theatre an supply of 2 of the clinicians bios and photographs.
Action Plan	10	Review of all risks to ensure captured in the risk log	Risk from all of the above actions are to be logged in the risk log and scored accordingly as to impact with current mitigations detail	Operational	Vascular Network Manager supported by Project support	Neil Rogers	01/04/2021			ongoing		In progress / Ongoing		24/10/21 Revised action plan in 1st draft for review at the vascular steering group 25th October 2021 30 December - updated action plan reviewed at VSG 16 December
	11	Review of all issues to be added to the issue log	Issues from all of the above actions are to be logged in the issue log and scored accordingly as to impact with current mitigations detail	Operational	Vascular Network Manager supported by Project support	Neil Rogers	01/04/2021			ongoing		In progress / Ongoing		Risks and Issues to be fixed agenda item on the CG meeting.
NVR Actions	12	Higher than UK average Mortality for major amputations (3 year rolling calculation)	MDT mortality review of all major amputations	Clinical	Soroush Sorabi	Ramesh Balasundaram			01/12/2021	31/01/2022		In progress	13 Jan for remaining cases review	MDT discussed 5 of the 9 amputees from December 2019. A further meeting is to be planned in January.
			Report of cases including lessons learned to be completed and shared with wider MDT	Clinical	Soroush Sorabi	Ramesh Balasundaram			07/12/2021	31/01/2022		In progress	13 Jan for remaining cases review	Discussed at CG meeting 10/12/21 and the remaining learning outcomes on 18 January 2022
	13	Incomplete data entry for NVR submissions	Improve data entry for IR cases across BCU	Operational	Helen Hughes	Nick Lyons			01/12/2021			Not yet commenced		IR consultants required to add NVR data / funding approval and recruitment required to support the B2 data entry person for vascular entry. 30 December - emailed Helen Hughes to escalate the issue.
			Require NVR data entry person	Operational	Sally Morris	Neil Rogers			01/12/2021	31/03/2021		In progress		Funding approval and recruitment required, submitted as part of vascular improvement for IMTP
	14	Cross ref to action point 6	Improve access to emergency theatres for Lower limb revascularisation / carotid endarterectomy / carotid patients / major amputation	Operational	Elaine Hodgson supported by Sally Morris	Neil Rogers			01/12/2021	30/04/2022		In progress		Discussed with Neil Rogers - need to review the possibility for additional emergency theatres. Additional CEPD list in place Fridays although not specific to vascular but increased access.
	4.1	Cross ref to pathways above	Repatriation pathway to be completed, signed off and utilised for admission to spoke sites from the hub	Operational	HoNs supported by DGMs and Clinical Leads	Acute Site Directors	01/04/2021	31/05/2021		31/03/2022		In Progress	Re-shared across spoke sites - some concerns raised by Care of the Elderly team. Aim sign off March 2022	Document previously completed and presented to CAG but anecdotally heard of some nursing concerns. For SM to pick up with HoN and liaise with counterparts at spoke sites 6/10/21 25th November update - requested CAG information to address all stakeholders and gain approval 3 December update - recirculated to Rhian Hulse, Keeley Twigg, Lesley Walsh and Ellie Kite for circulation again as been a year since agreement. It was held up at CAG as lack of evidence to support nursing involvement. Nursing clear involvement this time.
	3	Cross ref from above for theatres	Review theatre capacity and ensure all pre-covid lists are returned	Operational	Elaine Hodgson supported by Theatre Manager	Neil Rogers			01/11/2021	30/04/2022		Not yet commenced	Covid 4th wave - issues with staffing	Alternate Monday all day case list removed during covid 25th November update - issues with resource - prioritising lists in place due to staffing
	16	Prophylactic Antibiotics	Review the use of prophylactic antibiotics for amputees	Clinical	Soroush Sorabi supported by microbiology lead	Balasundaram Ramesh				31/01/2022		Not yet commenced		

ACTION LOG

The purpose of this template is to record all actions from Programme-related meetings, and to record the

Action Number	Work stream	Action Description	Action Owner	Action Date	Action Deadline
51021-01	Hybrid Theatre	Cancellation on the day reasons for each meeting review	Soroush / Angela	07/10/2021	21/10/2021
51021-02	Hybrid Theatre	Review SOP for cancellation of patients on the day	Angela Jones	07/10/2021	21/10/2021
180821-01	DFP West	LM to arrange new day and time for the meeting	Lea Marsden	18/08/2021	01/09/2021
210921-01	DFP West	SM to develop risk log	Sally Morris	05/10/21	19/10/2021
210921-02	DFP West	EG to agree generic MDT pathway with Jo and Gareth	Eryl Gilliland	05/10/2021	05/10/2021
210921-03	DFP West	LM & KM to agree stakeholders for West	Lea Marsden & Karen Mottart	05/10/2021	05/10/2021
210921-04	DFP West	SM to coordinate communication of pathways once agreed via the BCU Diabetic Foot Care T&F Group	Sally Morris	21/09/2021	01/01/2022
210921-05	DFP West	SM to support EG with gap analysis and data gathering at meeting scheduled for 24/09/21	Sally Morris & Eryl Gilliland	24/09/2021	28/10/2021
210921-06	DFP West	EG to coordinate data gathering - sent to SM. SM to review and share once interpreted. Need to understand even the unmet / unrecognised.	Eryl Gilliland / Sally Morris	21/09/2021	19/10/2021
210921-07	DFP West	EG to complete Gap Analysis for the next meeting on 2nd November 2021	Eryl Gilliland	21/09/2021	19/10/2021

210921-08	DFP West	LM to arrange meeting with EG and Carys Norgain, Eleri Roberts, Barry Williams, SM	Lea Marsden	21/09/2021	12/10/2021
051021 - 02	DFP West	Send amended pathways (middle box for management of ischaemia to be under shared care model under local protocol)	Eryl Gilliland	19/10/2021	19/10/2021
61021-01	DFP East	Steve & Nick to meet with Orthopaedic Surgeons on Audit day 9th November	Steve Stanaway	06/10/2021	09/11/2021
61021-02	DFP East	Sally to send activity for emergency presentations across BCU for Diabetic foot presentations	Sally Morris	06/10/2021	03/11/2021
61021-03	DFP East	All Management leads to review resource requirement (all disciplines / equipment etc.)	All East Management members	06/10/2021	21/10/2021
61021-04	DFP East	Agreement to support an initial once per month MDT on a Tuesday pm. Managers to review activity and protect time to allow this to take place within specialty	Nicola Joyce / Anthony / Laszlo / Patrick	17/11/2021	01/12/2021
61021-05	DFP East	Gareth to review Therapy manager to see if activity data can be pulled to assist in approximations of resource requirement for DFP implementation	Gareth / Nicola	06/10/2021	20/10/2021
61021-06	DFP East	Orchestrate vascular representation	Sally Morris	06/10/2021	20/10/2021
140921-01	DFP BCU	All members to forward comments to LM Re TOR	All members	14/09/2021	21/10/2021
140921-02	DFP BCU	LM to check the timing of the meeting	Lea Marsden	14/09/2021	03/10/2021
140921-03	DFP BCU	LM & SM to provide most up to date pathways to the Area groups for update and feedback whole pathway for agreement.	Lea Marsden / Sally Morris	14/09/2021	05/10/2021
140921-04	DFP BCU	LM & SM to agree a cascade list with each Area to support communications,	Lea Marsden / Sally Morris	14/09/2021	12/10/2021

140921-05	DFP BCU	BJ to progress discussions with ED colleagues for agreement about pathway referrals from Primary Care.	Beth Jones	14/09/2021	12/10/2021
12/10/2021	DFP BCU	SM to contact Eleri (Patient service to introduce ADL and BJ for further work with patient	Sally Morris	12/10/2021	09/11/2021
140921-06	DFP BCU	Sally to send activity for emergency presentations across BCU for Diabetic foot presentations	Sally Morris	14/09/2021	12/10/2021
121021-01	DFP Centre	FA to liaise with colleagues to develop written outline for the clinical agreement with orthopaedics.	Farhan Alvi	12/10/2021	26/10/2021
121021-02	DFP Centre	FA to take the proposal to consultant's meeting and BR to provide support if require	Farhan Alvi	12/10/2021	26/10/2021
121021-03	DFP Centre	BR to liaise with Steve Stanaway and Karen Mottart regarding cross-cover for specialist Foot and Ankle cases	Balasundaram Ramesh	12/10/2021	26/10/2021
121021-04	DFP Centre	SM to liaise with Steve Grayston to identify potential local community hospital / venue which could serve as a good venue for refurbishment to support rehabilitation	Sally Morris	12/10/2021	09/11/2021
26	Vascular resource	Review resource requirements for Middle grade with on call rota for vascular	Soroush Sorabi	13/10/2021	30/11/2021
27	Vascular resource	Review the additional Consultant resource requirements for both supporting DFP and centralisation	Sally Morris	13/10/2021	31/01/2022
28	Vascular resource	Review the issues surrounding Junior Doctors across vascular / surgery - meeting with Emma Woolley	Soroush Sorabi	13/10/2021	30/11/2021

29	Vascular resource	Review the resource gap for Specialist Nurses / ANPs for vascular across sites	Sally Morris / Sian Hughes Jackson	13/10/2021	30/11/2021
30	Admin resource	Review the resource required for admin to support the DFP for all specialties across BCU	Sally Morris	13/10/2021	30/11/2021
31	Admin resource	Review uplift in vascular required for MG and ANP clinics	Sally Morris	01/11/2021	30/11/2021
33	Governance	Review the meeting format / members / recording / feedback loop / dissemination / methodology	Sally Morris / Hans Desmorowitz	06/10/2021	09/11/2021
34	Governance	Set up teams channel for documents to be uploaded to as current process of vascular drive doesn't allow all to view	Sally Morris / Hans Desmorowitz	03/11/2021	24/11/2021
35	Governance	Source additional support for governance as a whole. Possibly give some clear actions to pending B5 / 7 appointment	Sally Morris	03/11/2021	30/11/2021
36	Governance	NVR Action plan to be completed post mortality review for amputees following the NVR report	Soroush Sorabi	27/11/2021	10/12/2021
37	Governance	M and M / Audit / CG to be separated in members and meeting times	Hans Desmorowitz	10/11/2021	10/12/2021
38	Audits	Feedback for outcomes and learning to be feedback to steering group and governance monthly	Soroush Sorabi / Hans Desmorowitz	03/11/2021	30/11/2021
41	Audits				
42	Spoke site engagement	Fortnightly meeting between Ops / Renal Nurses / Vascular Nursing / Rota co-ordinator to identify any shortfalls / clinical risk and plan remedies collaboratively	Sally Morris	16/09/2021	08/10/2021

43	Spoke site engagement	Fortnightly meetings for all relevant stakeholders required to improve communication and escalation	Sally Morris	05/10/2021	02/11/2021
44	Spoke site engagement	Improve rota link with spokes to confirm availability for planning with locum cover	Sally Morris	05/10/2021	02/11/2021
45	Spoke site engagement	Joint job planning - consider team job planning with spoke sites to cover all required activity	Sally Morris / Cheryl Goodall / Alison Davies	03/11/2021	31/01/2022
46	Spoke site engagement				
47	Spoke site engagement				
51	Capacity and demand	Capacity and demand for WMH required	Alison Davies	06/11/2021	20/11/2021
52	Capacity and demand	Capacity and demand for YG required	Cheryl Goodall	06/11/2021	20/11/2021
53	Capacity and demand	Capacity and demand required for YGC	Sally Morris	06/11/2021	20/11/2021
59	Pathways	IVDU Pathway - signed off by West / Vascular / Radiology Awaiting East Gen Surg / ED perspective	Steve Stanaway / Emma Caton	06/10/2021	06/11/2021
61	Pathways	Post Major Arterial Surgery - check status of sign off from MDs at spoke sites	Sally Morris	06/10/2021	20/11/2021
62	Pathways	Non-complex / Low vascular risk interventions pathway - check status	Sally Morris	06/10/2021	06/11/2021
63	Pathways	Create a non-complex / low vascular risk interventions pathway	Laszlo Papp / Soroush Sorabi	04/11/2021	31/12/2021
64	Pathways	Create and agree a transfer into ward 3 pathway	Sian Hughes Jackson	04/10/2021	21/12/2021
65	Pathways	Create and agree a repatriation post vascular intervention pathway	Sian Hughes Jackson	04/10/2021	21/12/2021
66	Pathways	Create a Primary care guidance / pathway for sharing with PC Medical Directors	Laszlo Papp / Soroush Sorabi	04/11/2021	31/12/2021
73	Reports	Highlight reports to be compiled for the BCU DFP meetings	Sally Morris	04/10/2021	12/10/2021

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091121-01	DFP BCU	All members to send comments or accept the TOR for the group pending tenure length following Ramesh meeting with Nick - ? Additional Nov 21 - March 22	All	09/11/2021	23/11/2021
091121-02	DFP BCU	Ramesh to discuss Plastic Surgery coverage for WMH	Balasundaram Ramesh	09/11/2021	23/11/2021
091121-03	DFP BCU	Patient information sent to Primary Care, need to determine if requires ratification from any Trust group	Gareth Lloyd Hughes	09/11/2021	23/11/2021
091121-04	DFP BCU	Following on from the discussion relating to Primary Care pathway - is there any mileage in emergent access to podiatry rather than ED referral where possible?	Gareth Lloyd Hughes / Bethan Jones	09/11/2021	23/11/2021
091121-05	DFP BCU	GLH to liaise with colleagues across BCU and provide Karen with the OPCS codes from joint podiatry / ortho / vascular / diabetes to collate activity	Gareth Lloyd Hughes / Bethan Jones	09/11/2021	23/11/2021
091121-06	DFP BCU	All members to forward Karen data that they would like to see collected	All	09/11/2021	23/11/2021
161121-01	DFP West	To commence fortnightly joint vascular / podiatry / ortho clinics from 16/23rd December with EG orthotic room availability. Room free for 4 months, then will need more permanent venue	Faisal Shaikh / Haroon Mumtaz / Eryl Gilliland	16/11/2021	23/12/2021
161121-02	DFP West	Review requirements for Consultant Connect and arrange training for podiatry to utilise via computer. Then determine any software or hardware requirements for the business case	Faisal Shaikh	16/11/2021	16/12/2021

161121-03	DFP West	Confirm any orthopaedic resource requirements to implement the pathway. Resource for joint fortnightly clinics with podiatry / outlying ward rounds / monthly MDT review and discussion / Admin etc.	Rhian Hulse / Haroon Mumtaz	16/11/2021	03/12/2021
161121-01	DFP Centre	SM to link in with Tom O'Driscoll /Sian Jones from ED relating to DFP implications for them	Sally Morris	16/11/2021	30/11/2021
161121-02	DFP Centre	Data supporting breakdown by specialty / length of stay etc. for emergency inpatient admissions for DFP	Sally Morris	16/11/2021	30/11/2021
161121-03	DFP Centre	Joanne Roberts to alter the DFP risk to being a site risk on the register	Joanne Roberts	16/11/2021	30/11/2021
161121-04	DFP Centre	Specialties - Diabetes / Orthopaedics / Vascular to review where they may able to provide short term additional sessions to softly introduce the DFP pending resource approval	DGMS / Specialty leads / Joanne Roberts	16/11/2021	30/11/2021
161121-01	DFP East	Need to review ED response to the DFP, Steve to send to Robin Roop. Possibly invite Robin to next meeting in Emma's absence.	Steve Stanaway	16/11/2021	01/12/2021
011221-01	DFP East	Review of East Podiatry needs	Gareth Lloyd Hughes	01/12/2021	15/12/2021
011221-02	DFP East	Update pathway with comments from recorded meeting / following Sally Morris discussion with vascular Friday 3/12/21 and Steve update from Orthopaedics on 10/12/21. needs completing and forwarding out prior to vascular steering group meeting 16th December	Nicola Joyce	01/12/2021	15/12/2021
011221-03	DFP East	Review / addition of detail to pathway to indicate contact numbers / email for podiatry for ED to use	Gareth Lloyd Hughes	01/12/2021	15/12/2021
141221-01	DFP West	Karen to review the incident described by Faisal to management of a diabetic foot at Bangor	Karen Mottart	14/12/2021	11/01/2022
141221-02	DFP West	Sister Scott to be informed of plans for OPD clinics and extend invitation	Sally Morris	14/12/2021	11/01/2022
141221-03	DFP West	Plan to be made for MDT Clinics and ward round for March with new diabetology Consultant arrival	Bethan Davies-Williams, Rhian Hulse and Sally Morris	14/12/2021	26/01/2022

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he action's owner, status and any further notes.

Revised Action Deadline	Issues affecting delivery	Remedial Action - In Place or Planned	Action Complete Date	Action status
17/11/2021			17/11/2021	Completed on time
	Flow chart in place		03/11/2021	Completed Late
			01/09/2021	Completed on time
			13/10/2021	Completed on time
	Generic only to podiatry and therapy services		05/10/2021	Completed on time
			05/10/2021	Completed on time
	MDs for each site will disseminate to relevant leads and departments for information		16/11/2021	Completed on time
				Completed on time
02/11/2021		Noted that Therapy manager information changes as search parameters are changed.	02/11/2021	Completed on time
02/11/2021			02/11/2021	Completed on time

			12/10/2021	Completed on time
02/11/2021	Awaiting receipt		02/11/2021	Completed on time
			09/01/2021	Completed on time
			08/10/2021	Completed on time
01/12/2021	Awaiting update from Claire Pool and Karen		22/11/2021	Completed on time
12/01/2022	Patrick / Hassan and Anthony planned to attend with Nicola once per month			Not yet due OR In Progress
			16/10/2021	Completed on time
01/12/2021			01/12/2021	Completed on time
09/11/2021			08/10/2021	Completed on time
			03/10/2021	Completed on time
			05/10/2021	Completed on time
			03/11/2021	Completed Late

			08/10/2021	Completed on time
			13/10/2021	Completed on time
			09/10/2021	Completed on time
25/01/2022		Email sent to colleagues - no pushback		Not yet due OR In Progress
25/01/2022				Not yet due OR In Progress
12/01/2022				Not yet due OR In Progress
		Suggesting Llandudno as a ready venue for refurb	09/11/2021	Completed on time
			23/11/2021	Completed on time
				Not yet due OR In Progress
			10/11/2021	Completed on time

			23/11/2021	Completed on time
			23/11/2021	Completed on time
			23/11/2021	Completed on time
			09/11/2021	Completed on time
21/12/2021			08/12/2021	Completed on time
			01/12/2021	Completed Late
			10/12/2021	Completed on time
			10/12/2021	Completed on time
			25/11/2021	Completed on time
			08/10/2021	Completed on time

			15/10/2021	Completed on time
			15/10/2021	Completed on time
				Not yet due OR In Progress
31/01/2022		SM commenced capacity		Not yet due OR In Progress
31/01/2022		SM commenced capacity		Not yet due OR In Progress
31/01/2022		SM commenced capacity		Not yet due OR In Progress
20/11/2021	Aw Gen Surg / ED East - 3 reminder emails sent 4/11/21	Escalate to NL if no response 9/11/21	20/11/2021	Completed on time
			03/12/2021	Completed Late
			29/0/21	Completed Late
			30/11/2021	Completed on time
25/01/2022		Emailed 2/12/21		Not yet due OR In Progress
31/03/2022		Emailed 2/12/21 for comments east and west		Not yet due OR In Progress
01/02/2021				Not yet due OR In Progress
09/11/2021			09/11/2021	Completed on time

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07/12/2021			07/12/2021	Completed on time
31/01/2022				Not yet due OR In Progress
14/01/2022				Not yet due OR In Progress
14/01/2022				Not yet due OR In Progress
14/01/2022				Not yet due OR In Progress
07/12/2021			07/12/2021	Completed on time
			16/12/2021	Completed
11-Jan-22				Not yet due OR In Progress

31/12/2021				Not yet due OR In Progress
14/01/2022		Email sent 17/11/21 and again 8 Dec		Not yet due OR In Progress
			3rd December	Completed Late
11/01/2022				Not yet due OR In Progress
14/01/2022		Jo Roberts emailed out		Not yet due OR In Progress
			01/12/2021	Completed on time
			15/12/2021	Completed on time
			15/12/2021	Completed on time
			15/12/2021	Completed on time
				Not yet due OR In Progress
				Not yet due OR In Progress
				Not yet due OR In Progress

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Comments	Assurance (how do we know the action has been delivered and embedded?)
Linking with informatics for weekly report	
New day and time scheduled	
risk log for the whole project in progress and will outline via work streams	
Agreed by West Group. Small change to mid point Vascular stage – to admit under shared care model under local protocol. To have caveats of minor process / difference on a page behind each pathway	
Noted lack of diabetologists – Bethan to feed into Jim McGuigan relating to accepting and implementing the pathway	
Ongoing, need to confirm wte total and what is then required for delivery of the pathways in line with East. Example SBAR sent for completion by Spoke sites	
EG reviewing data held in Therapy manager and awaiting information from Carys Park vascular nurse specialist to collate activity Data sent to Sally - requires review	

Meeting arranged for 12 th October 2021	
To be sent out with minutes / action log prior to next meeting	
Completed meeting and awaiting Orthopaedic pathways to be agreed with the team / Steve and Nick Lyons	
Emailed Alistair Edwards / Paul Griffiths for information 7/10/21 for more detailed information but previously gathered SS data sent with breakdown of admissions by site (week/month/year) sent out to all East / West / Centre members	Email trail
Rough estimates provided from Diabetology / Podiatry / Vascular	
Managers to meet and arrange a Tuesday pm once per month (wk. 1 or wk. 3 ideally for vascular). Room etc. to be arranged by NJ following determination of what will be completed in the session once a month	
Nicola sent over referral information to SM, activity relates to referrals into podiatry.	
1 comment received. Included in the meeting preparatory reading / agenda for further discussion 21/10/21 Queries raised by AD as to what the purpose of the meeting was and therefore should the TOR stands without Direction from SRO?	
Unable to move meeting times	
Pathways sent ahead of meetings to East / West / Centre/ BCU along with minutes and agenda etc. for review	Email trail

Bethan has made contact, awaiting ED response. ED Rep Nikki Sommers invited to BCU meeting 12/10/21	Email trail / invite
Emailed Eleri for direction	
Sent SS previous data collection. Chasing informatics for more detailed and regular information provision. Emailed Alistair Edwards / Paul Griffiths for information 7/10/21	Data sent to East / West / Centre along with agenda / minutes for meetings
Email sent to colleagues without reprisal	
Medical HR supported in modelling requirement for MGs. Next step prior to interview on 11/11 to determine Pas and payscales for the new model incorporating spoke cover rotational and late shift on calls / weekends	
Need to review capacity and demand and trajectory on current provision, increased MG and ANP in OPD (space allowing)	
Need to recruit mix of ANPs and PA s for ward cover / support and allow learning opportunity for SHOs. 2 PAs factored into investment piece	

Bangor has no Band 7 ANP/CNS - needs to be the same working model as other sites. WMH has no Band 6 CNS, as per point above - needs. ANP to be removed from the current ward activity and used as role intended. Work has started on this w/c 8/11 with work on backlog and ordering of scans / telephone appts. Visit to WMH to observe practice and share standards. Space is a risk - need a dedicated room to be shared between CNS and ANP at YGC.	
Baseline for current need reviewed by Nicci turner and Cally Hogbin - SM to link in with discussion for additional MG / ANP / Consultant impact on this.	
As above	
Meeting with governance 26th October and Hans Governance lead w/c 25th October to discuss TOR are on agenda for sign off. Nursing representation now attending with ward safety and quality reports	
CEG PowerPoints with pointers and sub headings sent to all medical staff for use to prompt learning outcome inclusion	
1st meeting completed successfully and addressed some WLI requirements for aiding better use of theatre lists to address long waiters and Urgent renal access patient plans. Shared learning from Vascular nursing teams	

Fortnightly meetings in pace with secretaries / ops / renal nurses / rota co-ordinator to review issues and forward look and updates on escalations. Good progress on renal access	
Rota-coordinator working closely with spokes to backfill lost activity / cover with locums pending recruitment	
Completed for WMH Hassan Jararah. Draft completed for Bangor Ruwan Fonsekah	
Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
Email sent with request 6/11/21 cc'd in Karen Carter to see if informatics can support a timely review across 3 sites	
Signed off at CAG	
Pathway not yet written	
Email confirmation from MDs to confirm and disseminate the minor vascular work compatible with spoke sites	
Discussed with HoNs at all sites. East and West no concerns raised. SHJ to take to CAG	
Sent for review East and West - discussed with HoNs and DGMs and disseminated with deadline 16/12/21 to go for CAG. Prior issues raised a no 'apparent' nursing involvement for pathway if patient not accepted	
Unable to complete this month, will be in place for next meeting	

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ISSUE LOG

The purpose of this document is to record all Programme-related issues and their mitigation

Definition of issue:

A relevant event that has happened, was not planned, and requires management action. It can be any concern, query, request for change, suggestion or off-specification raised during a Programme. Programme issues can be about anything to do with the project.

Issue ref	Work stream	Date issue raised	Description of the issue	Description of the cause and impact	Severity - Catastrophic/ Major/Moderate/Minor/ Negligible <i>please use dropdown</i>	Issue response action
1	DFP	01/12/2021	Failure to determine a single pathway across BCUHB for signposting the DFP patients into the correct specialties from ED	Failure to agree on a single pathway is preventing implementation of NICE guidance for managing patients with the diabetic foot	Major	East are liaising directly with Nick Lyons and West have signed off. Centre are raising some issues in relation to vascular and orthopaedics. Medical Director involved in trying to reach a consensus
2	DFP	01/12/2021	Failure to determine the resource required for DFP implementation due to no final resolute pathway	unable to commence business case without the identified resource gap and hence delay in delivery of patient pathway	Major	Fortnightly meetings continue. Escalation to DGMs
3						
4	Pathways	01/12/2021	Repatriation pathway progressed through CAG but then didn't receive Exec endorsement. Re-circulating 1 year on to progress through CAG / Execs	Patients remain longer than clinically necessary on ward 3 impacting upon cancellations on the day due to lack of bed availability and vascular patients being managed in non-vascular beds	Major	COTE team at West now have concerns - meeting to be planned for discussion
5	Pathways	30/12/2021	Failure to agree consensus on managing day case vascular patients requiring an overnight stay following general anaesthesia at East	Potentially meaning that patients would need to be transferred to YGC for the overnight stay prior to discharge.	Minor	Escalated to MD
6	Pathways	01/12/2021	Shared care model remains a contentious issue reducing the ability to keep vascular patients with minor issues at spoke sites. This is driven by lack of bed base and pressure to make use of surgical beds for the specialty in an already pressurised system	Potentially patients transferred to YGC for management that would be best places at spoke sites. Impact the same as repatriation above in beds being available to incoming patients and increased risk of cancellations on the day	Major	
7						
8	Governance	01/12/2021	Lack of robust capture and sharing of learning outcomes from vascular governance / practice	Lengthy meetings and discussions but not captured succinctly and shared which could prevent learning from incidents	Moderate	
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RISK LOG - The Risk Register provides a record of identified risks relating to the Programme, including its status and history. Programme and ensure that any risks which could impact on

Risk No	Risk Description	Impact Description	Risk Category	Inherent risk (score before action)			Date risk raised
				Probability Score 1-5	Impact Score 1-5	Overall Score	
1	Lack of resource within the vascular team across all grades	Currently unable to deliver required activity across all 3 sites as providing cover for VCOW and OC commitments in the first instance. Lack of Junior support for the ward, lack of MGs to provide sufficient support for all activity. ANP currently being absorbed into ward 3 to support due to junior staffing. Interim and permanent solution to admin support for the above will also be required to achieve timely outcomes	Quality/Safety	4	2	8	01/09/2021
2	Lack of resource of all supporting disciplines to support implementation of the DFP	All sites have so far been requested to provide estimates of what they think is required to implement the DFP as without this we are not meeting NICE guidance for managing the patient with a diabetic foot and creates delays for the patient journey	Quality/Safety	4	3	12	01/04/2020
3	Cultural and political issues currently posing a risk to delivery of the hub and spoke model of care	There is still a lot of frustration across the spoke sites that followed centralisation for vascular services and a feeling of being 'done to'. This is leading to some negative behaviour which is hindering development of robust processes between specialties across BCU. Some of this extends to teams refusing to sign up to pathways to improve patient experience / quality / reputation.	Quality/Safety	4	3	12	01/09/2021

4	Reluctance to adopt a formal Shared Care model at spoke sites	There is apparent unease across all specialities to adapt a shared care model to enable non-emergent vascular patients to be managed at spoke sites. This means that demand outstrips the current bed base at YGC and entails vascular patients to be admitted to other wards. Furthermore, this increases the risk of theatre cancellations due to lack of vascular bed availability	Quality/Safety	4	3	12	01/09/2021
5	Delays in timely diagnostics and assessments i.e. CT/MRI/Sonography	At the time of the RCS report there were reported delays in accessing diagnostics. Information has been requested from informatics to understand what the current position of this is although an SBAR written by BCU radiology lead describes human resource being an issue to deliver optimally which could delay urgent procedures or increase complications	Quality/Safety	4	3	12	01/04/2021
6	Repatriation pathway completion and sign off	This pathway has previously been taken to CAG but not approved. Further work is needed to ensure timely repatriation to spoke sites following vascular interventions. Central to this is agreement on terminology of shared care. This impacts on the number of vascular outliers at the hub site and could create a theatre cancellation on the day if no beds are available.	Quality/Safety	3	3	9	01/04/2021
7	Vascular bed resource and management	Ward 3 commonly has a high number of outliers (averages of 2.5 per day since April 2021) with regular high numbers of vascular outliers amongst other wards (average 5 per day since April 21) indicating the requirement of an increased bed base	Quality/Safety	5	2	10	01/04/2021

8	Lack of access to emergency theatres	Lack of emergency theatre leads to delays in treatment and can negatively impact on outcomes and mean failure to achieve national targets. It also leads to cancellations of more planned procedures which can also negatively impact outcomes and failure to achieve targets	Quality/Safety	3	3	9	01/04/2021
9	Data accuracy for NVR submission	There is a risk that both the data submitted to NVR has not been fully accurate historically. This can lead to performance data being published which identifies the organisation as an outlier	Reputational	3	3	9	
10						0	
11						0	
12						0	
13							
14							

It is used to capture and maintain information on all of the identified threats and opportunities relating to the delivery of the milestones is included in the risk register, and mitigation considered and recorded.

Action Owner	Actionee	Mitigation in place or required description	Residual risk (target score)		
			Probability Score 1-5	Impact Score 1-5	Overall Score
Soroush Sorabi / Sally Morris /	Sally Morris	2 Consultant Locums sourced to provide backfill cover. 1 for YGC / WMH (4/10/21) and on for YGC / YG (1/11/21) to ensure robust cover for spoke sites. Searching for locum Juniors / MGs to bolster YGC support Actions underway to determine activity for ANP to support OPD WL and patient management. New starting Consultant 10/1/22 who will support following induction	2	2	4
Leads / DGMS all areas across BCU	DGMs BCU Sally Morris to pull together	Current mitigation of non-adherence to a single pathway is that patients are managed through YGC if not at spoke sites although not managed by standardised protocols	3	3	9
Acute Site directors / Medical Directors	Leads / DGMS/ Specialist Nurses / Sally Morris	A Vascular Oversight group has been established led by the SRO with Medical and directors and the vascular Lead to expedite delivery of the action plan and manage obstacles. Meetings are currently in place between hub and spoke sites to attempt to alleviate issues. New Ops meetings with secretarial / specialist nurses / renal nurses have been implemented as of 7/10/21 in an effort to pull together to alleviate some bottlenecks in the service and work collaboratively.	4	2	8

Executive Medical Director	All Medical Directors, Sally Morris to support	Karen Mottart has agreed to pull a meeting of all Medical Directors to outline the accountability and responsibility of both the admitting specialty (name behind the bed) and the supporting specialty to attempt to make the concept more palatable to clinicians involved. MDs will then disseminate the documents down their respective medical / nursing / operational teams.	3	2	6
Executive Medical Director	Kakali Mitra	CT / MRI waiting times are compliant with the HBs guidance of 2 wks. urgent and 8 wks. routine. Sonography cannot become compliant until resource has been sourced	2	2	4
DGMs supported by clinical Leads	Vascular network manager	Patients are being managed via bed managers across the sites but progress can be less than timely Repatriation pathway re-shared to both spoke sites for review given 1year since previous discussion. Minor comments only - expect to have to CAG before end of December 2021	2	2	4
Acute Site Director	DGM supported by vascular network manager and HoN	Daily board rounds and escalation look to realign the beds but it doesn't make for an optimal patient journey. Ward 3 wish to ring-fence their beds for vascular patients in keeping with the emergency transfer pathways and to ensure the right patient in the right bed. Current figures indicate the requirement for an average of 23 beds per day for vascular patients and workforce would need to reflect this Agreement in principle to ring-fence 1 male and 1 female bed and to expand the bed base to 23	3	2	6

Balasundaram Ramesh	Theatres DDGM supported by vascular network manager and Soroush Sorabi	1 additional CEPOD list has been provided Fridays at YGC although not for vascular sole use. Issues lie with physical space and staffing. Need to review with theatre DGM to source other opportunity	2	2	4
		Consultants are requested to ensure that data is validated by NVR prior to benchmarking. NVR performance an data entry is a standard agenda item for clinical governance	1	3	3
					0
					0
					0
					0
					0

to the Programme. Please link into the milestones listed for this

Further Action Planned. (Who, What, Why and When anything more will be done to deduce the Residual risk)	Risk Open or Closed	Date Risk Closed DD/MM/YYYY	Risk uploaded /updated on Datix
Capacity and demand review along with review of job plans for all clinicians within vascular is required to build into the business case to manage the hub and spoke model robustly	Open		
Business case approval and recruitment will be required across all disciplines BCU wide to achieve the DFP implementation	Open		
Time and continued collaborative work will be required to further improve the situation. Escalation will be required for continued problematic behaviours to HMT and the SRO	Open		

What is a risk?

- A risk is an event, or a set of related events
- It must be possible, but not necessary, for the event(s) to occur
- The event(s), were it (or they) to occur, would impact on the objectives of the programme (i.e., wheth

YGC will need to ensure that cases transferred unnecessarily are captured and audited to feedback and address remaining issues	Open		
Business case approval required and then lead time for recruitment	Open		
Audit required for repatriation in terms of when bed requested and when repatriation occurred	Open		
Ward 3 and HoN are keen to develop a high observation bay to 1) make the recruitment option more attractive ") give a wider ability to grow our own senior staff 3) allow earlier step down from HDU areas to free beds for theatre patients reducing delays and cancellations	Open		

• *This impact can be either positive (an ‘opportunity’) or negative (a ‘threat’).*

Review of whole theatre schedule to see if there is scope to increase access to emergency theatres			
NVR Data entry clerk has been factored into the resource requirements for Vascular improvement programme	Open		

her, or how, they are achieved)

RISK REGISTER SCORING AND RATING

	LIKELIHOOD SCORING				
LIKELIHOOD SCORE	1	2	3	4	5
Frequency/How likely is it to happen?	This will probably never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but is not a persisting issue or circumstance	Will undoubtedly happen/recur, possibly frequently

Category	Consequence (Impact) Scoring				
Consequence Score	1	2	3	4	5
Descriptor	Negligible (Very Low)	Minor (Low)	Moderate	Major (High)	Catastrophic (Very High)
Quality/Safety	Minor reduction in quality in treatment or service No or minimal effect on patients/staff/ others	Single failure to meet national standards of quality or treatment or service Low effect for a small number of patients/staff/ others if unresolved	Repeated failure to meet national standards of quality of treatment or service Moderate effect for a small number of patients/staff/ others if unresolved	Ongoing non-compliance with national standards of quality of treatment or service Significant effect for numerous patients/staff/ others if unresolved	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for large numbers of patients/staff/ others if unresolved
Reputational	Not relevant to organisational goals No adverse media coverage No negative recognition from the public	Minor impact on achieving organisational goals Low level of adverse media coverage Small amount of negative public interest	Moderate impact on achieving organisational goals Moderate amount of adverse media coverage Moderate amount of negative public interest	High impact on achieving organisational goals High level of adverse media coverage Negative impact on public confidence	Organisational goals will not be achieved National adverse media coverage Total loss of public confidence
Finance	Small loss Risk of claim remote	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non-delivery of strategic goal Deficit greater than £1m Failure to meet specification Claims in excess of £1 million
Regulation	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation	Single breach of statutory duty Challenging external recommendations	Enforcement action Improvement notice Multiple breaches in statutory duty Critical report	Continued breaches in statutory duty Prosecution Severely critical report Complete system change required

	CONSEQUENCE				
LIKELIHOOD	Negligible (Very Low)	Minor (Low)	Moderate	Major (High)	Catastrophic (Very High)
Will undoubtedly happen/recur, possibly frequently	5	10	15	20	25
Will probably happen/recur, but it is not a persisting issue	4	8	12	16	20
Might happen or recur occasionally	3	6	9	12	15
Do not expect it to happen/recur but it is possible it may do so	2	4	6	8	10
This will probably never happen/recur	1	2	3	4	5

ISSUE CONSEQUENCE SCORING

	Consequence (impact) Scoring				
CONSEQUENCE SCORE	1	2	3	4	5
Descriptor	Negligible (Very low)	Minor (Low)	Moderate	Major (High)	Catastrophic (Very High)
Quality/Safety	Minor reduction in quality in treatment or service No or minimal effect on patients/staff/others	Single failure to meet national standards of quality or treatment or service Low effect for a small number of patients / staff / others if unresolved	Repeated failure to meet national standards of quality of treatment or service Moderate effect for a small number of patients / staff / others if unresolved	Ongoing non-compliance with national standards of quality of treatment or service Significant effect for numerous patients/ staff/ others if unresolved	Gross failure to meet national standards with totally unacceptable levels of quality of treatment or service Very significant effect for large numbers of patients/ staff/ others in unresolved
Reputational	Not relevant to organisational goals No adverse media coverage No negative recognition from the public	Minor impact on achieving organisational goals Low level of adverse media coverage Small amount of negative public interest	Moderate impact on achieving organisational goals Moderate amount of adverse media coverage moderate amount of negative public interest	High impact on achieving organisational goals High level of adverse media coverage Negative impact on public confidence	Organisational goals will not be achieved National adverse media coverage Total loss of public confidence
Finance	Small loss Risk of claim remote	Deficit of £100,000 or less	Deficit of £100,000 to £500,000	Deficit of £500,000 to £1m	Non delivery of strategic goal Deficit greater than £1m Failure to meet specification Claims in excess of £1m
Regulation	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation	Single breach of statutory duty Challenging external recommendations	Enforcement action Improvement notice Multiple breaches in statutory duty Critical report	Continued breaches in statutory duty Prosecution Severely critical report Complete system change required

ISSUE SCORING MATRIX

Consequence scoring

5	Catastrophic
4	Major
3	Moderate
2	Minor
1	Negligible

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience (QSE) Committee 11 th January 2022						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Vascular Steering Group Update						
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons, Executive Medical Director						
Awdur yr Adroddiad Report Author:	Neil Rogers, Acute Care Director (YGC)						
Craffu blaenorol: Prior Scrutiny:	The revised action plan was reviewed by the Vascular Steering Group (VSG) on the 16 December 2021						
Atodiadau Appendices:	Updated Vascular Action Plan						
Argymhelliad / Recommendation:							
The Committee is asked to note progress in delivery of the Vascular Improvement Plan							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	X
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>This report provides an update on delivery of the Vascular Improvement Plan produced in response to the review by the Royal College of Surgeons (RCS) of the vascular service. The first report by the RCS was received in 2021 and the second report is now expected in February 2022, this report will primarily focus on the quality of the service informed by a review of clinical cases.</p> <p>The Vascular Oversight Group was established in September 2021 and meets on a fortnightly basis. This group is chaired by the Executive Medical Director and includes senior clinical leadership from all 3 acute sites.</p> <p>The revised action plan attached to this report has been reviewed at the Vascular Steering Group on 16th December 2021 and will be reviewed monthly thereafter, further actions being added as needed and with particular focus on ensuring that completed actions have been validated.</p> <p>This is overseen and supported by the Vascular Steering Group.</p> <p>The National Vascular Registry (NVR) report was received in November 2021 and highlighted quality issues in particular related to outcomes in major amputations. Key actions in response to this report are highlighted in this paper.</p>							

An external review of the data relating to amputation for the last 5 years has been commissioned and will report in January 2022.

Cefndir / Background:

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

The second stage of this review, based on the analysis of 50 case notes, began in July 2021. It was expected that this report would be available in September 2021 but the College now advise that this is likely to be February 2022. This review is expected to give further insight into both patient safety and patient experience within the service. This is anticipated to lead to additional actions being taken forward or revision of existing actions.

Asesiad / Assessment & Analysis

Strategy Implications

The action plan is being monitored at the Quality, Safety and Experience Committee and the current refresh of the governance arrangements around the response to the review and the review of progress in delivering the action plan reflect the comments received at previous meetings. The current action plan is appended to this report, but key updates include:

Improve communication and team working across hub and spoke sites

Day case activity such as simple renal access, angioplasty, minor amputations, debridement and varicose vein procedures can be undertaken at spoke sites to provide this activity as close to home as possible for the patient.

The Vascular Network Manager is meeting fortnightly with site operational, vascular and renal nursing teams to ensure that there are clear lines of communication and plans to address waiting list backlogs, renal access patient management and consistency of senior medical cover.

The Oversight meetings and the local diabetic foot meetings also provide a robust platform for open discussion across the network and allow for good communication between.

Develop the non-arterial diabetic foot pathway

The clinical aspects of these pathways are now agreed. There remains some detail to be finalised around which team is responsible for patients at presentation, but these pathways are now progressing through local governance and sign-off processes which will complete March 2022.

Pathways

The management of a patient presenting with groin swelling with a history of Intravenous Drug User has now been approved at the Clinical Advisory Group (CAG) and has been implemented. Adherence with the pathway will be subject to audit and feedback.

National Vascular Registry (NVR) Report and improvements in data collection

The reported high post-amputation mortality in 2018/2019 is still causing the 3 year rolling average to flag as an outlier, compounded by more recent data validation errors which have become apparent on on reciet of the NVR report

A thorough MDT review of cases for 2019/2020 mortality was held on 7th December 2021. This process will be embedded. Learning points included

- Increased governance relating to decision making and the multidisciplinary (MDT) meetings
- Attendance at the MDT meetings has been further defined and formalised
- Quality assurance of data submitted going forward

Opsiynau a ystyriwyd / Options considered

Next steps

1. The review of current risks to ensure they are covered in the revised action plan risk log (action reference 4) is an ongoing part of the agenda VSG
2. To further increase the engagement with teams across BCU to work more collaboratively to support the agreed hub and spoke model of care, facilitated by the Vascular Oversight Group that is now in place (action reference 4.1.4, 4.2.11, 4.2.15, 4.2.16)
3. To note the second phase of RCS report anticipated February 2022

Goblygiadau Ariannol / Financial Implications

Subject to prioritisation, the IMTP will include an investment in Vascular Services.

Dadansoddiad Risk / Risk Analysis

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

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

There are no legal implications associated with this report.

Asesiad Effaith / Impact Assessment

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

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 11 th January 2022				
Cyhoeddus neu Breifat: Public or Private:	Public				
Teitl yr Adroddiad Report Title:	Corporate Safeguarding Six-Month Report (Q1-Q2) 2021-2022				
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy CEO/Executive Director Nursing and Midwifery Michelle Denwood, Director of Safeguarding and Public Protection				
Awdur yr Adroddiad Report Author:	Frances Millar, Head of Safeguarding Adults Chris Weaver and Mark Parry, Heads of Safeguarding Children Chris Walker, Head of Safeguarding Adults MHL D Supported by Michelle Denwood, Director of Safeguarding and Public Protection				
Craffu blaenorol: Prior Scrutiny:	Gill Harris, Deputy CEO/Executive Director Nursing and Midwifery				
Atodiadau / Appendices:	Appendix 1 – Quarter 3 & 4 Priority Action Plan				
Argymhelliad / Recommendation:					
The Committee is asked to accept the six-month Safeguarding People at Risk of Harm report for the period of 2021-22 (Q1-Q2) To receive the Safeguarding People at Risk of Harm Q3 and Q4 Priority Action Plan					
Ticiwch fel bo'n briodol / Please tick as appropriate					
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	Ar gyfer Trafodaeth For Discussion	Ar gyfer sicrwydd For Assurance	X	Er gwybodaeth For Information	X
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable				Y/N	
Not applicable					
Sefyllfa / Situation:					
<p>The Safeguarding People at Risk of Harm and Deprivation of Liberty Safeguards (DoLS) agenda is governed by The Social Services and Well Being (Wales) Act 2014, and the Mental Capacity Act (MCA) and other supporting legislation and guidance.</p> <p>Safeguarding Reporting has identified an upward trend in activity, both in the number of incidents and in the complexity. The initial lockdown in March 2020 proved to be an exception to this trend, which reported a reduction in safeguarding reporting, which was mirrored across Wales.</p> <p>The wider activity associated with the Safeguarding Public Protection agenda, Modern Day Slavery, Human Trafficking, County Lines, Sexual Exploitation and online exploitation continues to grow in demand and complexity.</p>					

Cefndir / Background:

Performance Activity.

Within Q1 & Q2 the Corporate Safeguarding Team have received 724 Adult at Risk reports and 1,687 Child at Risk reports from across BCUHB (this includes reports in relation to individuals who receive commissioned care out of county). This is an increase of 6% on the same reporting period in 20/21 for adults and 11% for children. The East continues to see a significant increase in reports being submitted with a trend of neglect for both adults and children.

Whilst work is ongoing to understand this upward trend, improved staff awareness may be contributing to the earlier identification of individuals at risk.

Within the same period, there have been 163 Adult at Risk Reports raised by the MHL D Division, which equates to 22.5% of all Adult at Risk Reports received. Compared to the same period in 2020-21, this is a 26% decrease in reporting by the division and may be a result of a targeted approach in safeguarding training and education. The MHL D Division utilise the Corporate Safeguarding Designated Safeguarding Person (DSP) in their area to agree preventative measures to support the patient prior to any concerns being raised. We actively review a reduction in reporting.

Multi-agency Domestic Abuse activity and engagement continues to increase. The number of Multi –Agency Risk Assessment Conferences (MARAC) referrals generated by Health Professionals for Q1 and Q2 is 95 compared to 93 generated in the same period last year. Health Visitors have completed the highest numbers of MARAC referrals, accounting for 31%. Midwives have completed 16% of referrals and the Emergency Department have completed 12%. The Routine Enquiry Domestic Abuse audit across all three Emergency Departments will review the current position, with the objective to improve wider organisational engagement in the identification of Domestic Abuse.

It is reported that between the periods of July to September 2021, there have been 1269 Datix incidents in relation to slips, trips, falls and collisions. The challenge for Corporate Safeguarding is to be assured that the incident handler is assessing the risk and considering if the incident meets the Adult at Risk threshold. There remains no consistent correlation between the Falls data and Adult at Risk reporting. Corporate Safeguarding are co-authors of the revised Falls Policy incorporating the All Wales Safeguarding Procedures. Level 1 Training has been developed jointly with Wrexham Local Authority and the correlation between risk and falls is included within Level 2 Manual Handling Training which is mandatory. Alongside the training packages and the review of the reporting systems, this will provide improved assurance and reduce multiple falls.

The Safeguarding - Deprivation of Liberty Safeguards (DoLS) Team have received 1,019 applications between April and November. The increase (44%) evidences the continued increase in the DoLS activity. The figures alone do not reflect the level of complexity and demand upon the DoLS/MCA service. To mitigate the risk of unlawful detention the team actively aim to review each application daily and liaise with ward staff to ensure that patients are still subject to the DoLS framework.

Child and Adolescent Mental Health Service (CAMHS).

There was an increase of 22% in section 136 assessments for May & June 2021. However, there has been a downward trajectory in the number of assessments in this period.

The lack of social care placement (UK wide concern) has led to several delayed discharges from the s136 suite, North Wales Adolescent Service, and paediatric wards. Corporate Safeguarding continue to offer specialist support and advice.

Domestic Homicide Reviews (DHR'S) / Adult and Child Practice Reviews.

There are currently three live DHR's with three awaiting sign-off by the Home Office. Identified learning includes improving information recorded on electronic systems, sharing of legislative information with GP practices, increased availability of Violence Against Women Domestic Abuse Sexual Violence training for GPs and audits of clinical records in relation to Domestic Abuse Targets.

There are currently four Child Practice Reviews taking place across North Wales. The incidents include two child hangings and a death of a baby by drowning. All identified learning will have full engagement from BCUHB.

Currently there is one live Adult Practice Review (APR) all other APRs to date have been published. Communication, Training, Self-Neglect and Care Coordination remain the most common themes.

Identification and Referral to Improve Safety (IRIS).

The IRIS programme involves training and support for GPs to be able to identify patients affected by domestic violence and abuse and refer them to specialist services. IRIS provides a unique opportunity for primary care clinicians and their patients to talk about the issue. There are current challenges as to which Primary Care cluster will participate in this pilot and a potential for the Domestic Abuse Safety Unit to utilise the monies elsewhere if this is not resolved.

Pilot project for the Independent Domestic Violence Health Advocate (IDVA) role in BCUHB.

Funding has been received from the Ministry of Justice (MOJ) to pilot two hospital based IDVA, one in YGC (Ysbyty Glan Clwyd) and one in YG (Ysbyty Gwynedd). The Hospital based IDVA will provide immediate, high quality, trauma informed support and advice to victims of domestic abuse accessing YGC and YG and link survivors to longer term community-based support.

Coping with Crying.

Following a Child Practice Review involving, a 10-month-old baby who suffered a Non-Accidental Injury (NAI) it was recommended that BCUHB review and audit compliance with the Coping with Crying Guidance.

Asesu a Dadansoddi / Assessment & Analysis

Within the Adult at Risk agenda, falls is one objective where development and improvement are a priority for BCUHB.

Desktop Reviews to improve and evidence improvement and compliance.

During a desktop review following the report of multiple falls for the same patient; case specific and safeguarding supervision, reflective learning, enhanced training, and intervention was undertaken and supported the reduction of future risk and harm.

Embedding the findings from the case is to be implemented across BCUHB to improve the correlation between Falls and Adult at Risk reporting on the Datix system.

Corporate Safeguarding continues to monitor and triangulate Datix Reports and Adult at Risk Reports to identify themes, trends and/or omissions.

Audit Quality of Adult Safeguarding Documentation.

During 2020-2021 a number of Desktop Reviews were undertaken and identified missed opportunities or common themes relating to poor quality documentation and recording. As a result, a randomly selected audit was completed across adult services and the MHLD Division for Q1/Q2. The findings demonstrated improvement in the consistency of the quality of the reports and associated safeguarding documentation. However, in areas where reports were deemed inferior, issues were addressed directly with the respective service.

Child At Risk Audit Activity.

A retrospective audit has been completed, focusing on Child at Risk reports. This was a priority action following evidence of the poor quality of reports in the previous quarter. A report and action plan will be developed across Q3 following the completion of this audit.

Routine Enquiry into Domestic Abuse (REDA).

This audit is completed annually as a result of recommendations from a number of Domestic Homicide Reviews. The improvements in REDA could be partially attributed to the restrictions in visiting during the COVID-19 pandemic, giving midwives the opportunity to see pregnant women alone.

Deprivation of Liberty Safeguards Audit.

Out of the 1,019 DoLS applications in the identified period 28% of the applications contained some issues or concerns that resulted in them having to be returned to the Managing Authority (Ward).

Comparison data for the period 2020-2021 identified 44% of applications evidenced some form of documentation error. The improvement is a direct result of a targeted intervention delivered directly to staff and wards.

The Mental Capacity (Amendment) Act 2019 will have significant implications in terms of demand, capacity, training, financial resources, and challenges for the Health Board. Work is in progress to support the implementation of Liberty Protection Safeguards (LPS) as required by the UK Government.

Deprivation of Liberty Safeguards, Court of Protection (CoP).

The number of cases engaged in Court of Protection activity has increased significantly. Cases may take months for the Court to conclude due to the amount of evidence and complexity with each case resulting in several hearings. The increase in complex CoP cases has resulted in additional costs to the Health Board.

A DoLS Standard Operating Procedure and Section 21a Appeal Process to facilitate cooperation, escalation, and coordination has been developed to improve and support engagement within the Health Board. This will be audited in the next period.

Training.

The BCUHB Corporate Safeguarding Training plan has been successful in maintaining a presence in the clinical areas to support staff. Virtual training continues to be provided. Group and individual supervisions are being delivered either virtually or when safe to do so face to face. The virtual platform has aided in communication and engagement with services internally and externally with partner agencies.

The mandatory training compliance position for both Adults and Children is between 81% and 86%. There has been no overall decrease in compliance from Q1 to Q2. As a result of enhanced intervention we have seen a positive trajectory in key areas. Areas reporting a poor compliance such as the three Emergency Departments and BCUHB Managed GP Practices are a key target area.

Violence Against Women Domestic Abuse Sexual Violence training compliance is 71.3% and is below BCUHB key performance indicator of 85% in key areas across the organisation. The reasons include staff inability to book the training, as the places are fully booked on ESR (Electronic Staff Record). However; the cap for booking has been increased to 80 but may require a further increase to unlimited places to meet the demand for VAWDASV training.

Recruitment.

Recruitment to the vacant post of Named Doctor Children remains to be a challenge. Interim arrangements are in place to support the strategic agenda and additional activities are taking place to undertake a service review.

Opsiynau a ystyriwyd / Options considered

Non-Applicable.

Goblygiadau Ariannol / Financial Implications

There are no financial implication for this report.

Dadansoddiad Risk / Risk Analysis

Risk ID 3766 Tier 1. There is a risk that BCUHB fail to deliver their statutory Duty of Care to Adults and Children at Risk, due to the increase in activity and complexity.

Risk ID 2548 Tier 1. The increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

The additional funding requirements and activities are included in the Integrated Medium Term Plan 2022-2025.

Asesiad Effaith / Impact Assessment

All Policies, Procedures, documentation, and safeguarding activity that impacts upon patients, staff or the organisation are in line with a supporting EqlA (Equality Impact Assessment). Consultation and engagement will take place with both internal and where appropriate external stakeholders.

Corporate Safeguarding Priority Actions Quarter 3 & 4 for 2021-2022					
Priority	Action	By Whom:	By When:	Updated Position	RAG Status
Safeguarding Adults					
1	Successful recruitment of all vacant posts within Corporate Safeguarding and consideration of the Service Review.	Heads of Safeguarding	December 2021	Included within the Integrated Medium Term Plan 2022- 2025 Four vacancies remain in the recruitment process.	AMBER
2	Regional Safeguarding Adult/ Dementia Lead, commence mapping and scoping for under and over reporting of incidences for those individuals living with dementia receiving care on our general wards, community hospital and primary care.	Head of Safeguarding Adults	March 2022	Initial scoping commenced however the post holder is currently covering Area Managers Post due to the vacancy.	AMBER
3	To support the Sexual Safety Group with training and evaluation of the co-produced MHL D guidance for patients and staff.	Head of Safeguarding Adults MHL D	March 2022	Following further consultation, it was agreed that an updated draft will be produced. The Plan for training dates remains a key action.	AMBER
4	Implement recommendations from Adult & Child Practice Reviews and Domestic Homicide Reviews and embed in safeguarding training.	Corporate Safeguarding Team	October 2021	Recommendations from Reviews are embedded and regularly reviewed and reflected in the safeguarding training. The effectiveness of the training is evaluated in Audit activities/incident reviews and Multi-agency case reviews.	GREEN

Appendix 1

				It is a standing agenda on the BCUHB Safeguarding Forums. Action completed	
5	Corporate Safeguarding to implement an internal process for the approval, review, and internal evaluation of all safeguarding training and performance programmes.	Corporate Safeguarding Team	March 2022	Discussions commenced with the Practice Development Lead. Draft documentation in consultation.	AMBER
6	Benchmark recommendations from National/Regional Adult Safeguarding Reviews and investigations.	Head of Safeguarding Adults Head of Safeguarding Adults MHL	March 2022	University of Cardiff have undertaken a Thematic Review of Adult Practice Reviews. Work has commenced for both Heads of Safeguarding Adults / Adult MHL to cross-reference the recommendations against practice in North Wales.	AMBER
7	Corporate Safeguarding to promote and provide further training to recruit up by 25% further Safeguarding Ambassadors for BCUHB.	Safeguarding Managers	October 2021	Action completed	GREEN
8	Falls - <ul style="list-style-type: none"> To support in the implementation of the new BCUHB Falls Policy. To work with Head of Quality Assurance to scope a system to correlate multiple falls with Adult at Risks. 	Head of Safeguarding Adults	April 2022	Awaiting final ratification. Initial discussions have taken place. Agreement and meeting set with Wrexham Local Authority.	AMBER

	<ul style="list-style-type: none"> To scope how Safeguarding can be incorporated onto NIIPS in particular multiple falls. To jointly review the Falls Guidance from the NWSAB. 				
9	To jointly develop a consistent Routine Enquiry Domestic Abuse audit across all three Emergency Departments.	Head of Safeguarding Adults Safeguarding Managers Heads of Nursing ED	April 2022	Further meetings arranged for Q3.	AMBER
10	To develop a Was Not Brought Procedure for BCUHB for Vulnerable Adults following recommendations from the Gwent APR.	Head of Safeguarding Adults	April 2022	In progress with consideration to be given this may be undertaken jointly to include Children "Was not Brought".	AMBER
11	Modern Day Slavery, County Lines and Prevent training to be scoped and widened to other adult areas, outside of MHL, for Level 3 training.	Head of Safeguarding Adults Safeguarding Managers	April 2022	Bespoke training to commence in ED in Q 4 following agreement with Heads of Nursing ED.	AMBER
VAWDASV and Midwifery					
12	Women's Division to lead, with support/engagement from the Safeguarding Midwifery Lead, on an audit of compliance with the Coping with Crying Guidance.	Head of Midwifery/Safeguarding Midwifery Lead	March 2022	A Task and Finish Group has been developed. Audit commenced in October 2021.	AMBER

13	To review the safeguarding midwifery service with full staff engagement.	Head of Safeguarding Children/Safeguarding Midwifery Lead	March 2022	Terms of Reference agreed. Review commenced in November 2021.	AMBER
14	To undertake the Routine Enquiry Domestic Abuse Audit for 2021-2022 to provide continued assurance of improvement and compliance.	Safeguarding Midwifery Lead	March 2022	Q1&2 data has been collated and analysed.	AMBER
15	Corporate Safeguarding to continue with their support to the implementation of the IRIS Pilot.	Head of Safeguarding Children	March 2022	Meetings have taken place with the Primary Care Clusters and the Domestic Abuse Safety Unit. Awaiting agreement on which Cluster would like to pilot the project.	AMBER
16	Corporate Safeguarding to work with the Domestic Abuse Safety Unit and Gorwel in the recruitment of hospital Independent Domestic Violence Advocates.	Head of Safeguarding Children	March 2022	This business proposal has been funded. Actions are in place for the start date of the new appointments. Appointments to start in February 2022.	GREEN
Safeguarding Children					
17	To develop a Strategic Implementation Group with supporting working groups, to drive Children's (Wales) Act 2020 forward, ensuring BCUHB will be compliant with their statutory duties.	Head of Safeguarding Children/Safeguarding Specialists	February 2022	Ongoing.	AMBER
18	To develop a BCUHB Strategic / Operational action plan in line the Welsh Governments National Action Plan	Head of Safeguarding Children	April 2022	Steering group and terms of reference formed in Q3.	AMBER

	preventing and responding to Sexual Abuse.				
19	Form a Task and finish group to explore the increase in use of 136 suites (increasing number of complex safeguarding issues).	Head of Safeguarding Children	April 2022	Steering group formed in Q3, setting out Terms of reference and membership.	AMBER
20	To review and offer analysis and report based on data from (Q2-Q3), regarding increased Child at Risk Reporting in the East of BCUHB region.	Head of Safeguarding Children	April 2022	On-going work to explore trends, themes from data provided.	AMBER
21	To support the update of the Standard operating procedures relating to : <ul style="list-style-type: none"> • Use of Cameras in Children protection medicals. • New Radiology Protocol in Paediatrics. 	Head of Safeguarding Children / Named Doctor for Safeguarding	March 2022	On-going work stream. Working with Paediatrics and Radiology. Audit activity to gain assurance regarding the current interim agreed procedure. – Q3/4.	AMBER
22	To develop and understand the impact on BCUHB service relating to Unaccompanied Asylum seeking Children and Young People who may be placed in the North Wales region.	Head of Safeguarding for Children	January 2022	Scoping exercise to ascertain current position. Engagement with external local authority partners. The outcome will determine any actions and engagement.	AMBER
23	To review the Child at Risk data capture process within BCUHB (returns from Local authorities).	Head of Safeguarding for Children	February 2022	Review of the current process has commenced. Use of e-survey to ascertain Outcomes being communicated to the primary reporter (WSSP 2020).	AMBER

DoLS /MCA/ LPS					
24	To create a BCUHB Liberty Protection Safeguards (LPS) Implementation Group, which will include strategic and operational membership to ensure the full implementation of the new Mental Capacity (Amendment) Act (2019) and code of practice relating to the LPS.	Head of Safeguarding Adults MHL Head of Safeguarding Adults	January 2022	LPS ToR completed and to be presented at the Safeguarding Governance and Performance Group (SGPG). Awaiting MCA/LPS Code of Practice from UK Gov. No date provided.	AMBER
25	Implementation of the Safeguarding Business Case to support the service to comply with the SSWWA 2014 and the provision of a 7 day service.	Director of Safeguarding and Public Protection	April 2022	Included within the Integrated Medium Term Plan 2022- 2025	AMBER
26	Review the training compliance to ensure accuracy and target training data is on ESR.	Head of Safeguarding Adults MHL	April 2022	Ongoing activity in relation to ESR recording and compliance. For completion during Q4.	AMBER
27	Ratify and Monitor the implementation of the strengthened Court of Protection and S21A Appeal process.	Head of Safeguarding Adults MHL Director of Safeguarding and Public Protection	January 2022	Documents updated following wider consultation and amendments and will be presented at Safeguarding Governance and Performance (SGPG) for approval.	AMBER
28	Documentation Audit.	Head of Safeguarding Adults MHL	April 2022	Audit completed in Q3. Further 'year-end' audit planned for Q4.	AMBER

Appendix 1

29	Confirm and engage with the BCUHB Mental Capacity Act Lead.	Head of Safeguarding Adults MHL Head of Safeguarding Adults	April 2022	In progress.	AMBER
30	Review and implement the bespoke training package for Authorisers.	Head of Safeguarding Adults MHL	March 2022	In progress. Activity has started in the East and will now be replicated in the West and Central.	AMBER
31	Welsh Government funding, actions and objectives – to be implemented by Q4.	Head of Safeguarding Adults MHL Director of Safeguarding and Public Protection	March 2022	Additional Best Interest Assessments are underway, this has resulted in an immediate and positive impact on the current DoLS Backlog. A scoping exercise has been agreed across services to explore current levels of MCA understanding. LPS Leads have been appointed to complete this work and progress the MCA agenda and awareness. East Read materials to be sourced to further support MCA understanding and awareness.	AMBER



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Quality Assurance Review of Morfa Ward – Improvement Plan						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance						
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance Jo Whitehead, Chief Executive Officer						
Atodiadau Appendices:	Action Plan						
Argymhelliad / Recommendation:							
The Committee is asked to receive the report.							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	√	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>This report provides the Committee with a summary of the improvement plan in place following the Quality Assurance Review of Morfa Ward at Llandudno General Hospital.</p> <p>A detailed improvement plan with current status and evidence is maintained by Corporate Quality Assurance for scrutiny by the Improvement Group. The arrangements for development and scrutiny of the plan are detailed below.</p> <p>As a result of clinical and operational pressures, full development of the plan has not been possible. The commitment made was to co-design the plan with stakeholders particularly those external stakeholders who contributed to the review and regrettably, this was not achievable within the timeframe. The summary presented for the Committee therefore reflects the position at the time of writing (31 December 2021). Recognising the importance of this work it is intended a full plan is in place by the end of January 2022, one month behind the initial deadline.</p> <p>In terms of the development process for the action plan, the following has been agreed:</p>							

1. Recommendations have been divided into 5 work-streams (detailed below) with a senior director level lead allocated for each. The senior lead will identify individual improvement action owners to develop the actions in co-design with key stakeholders.
2. The final Improvement Plan will be presented to the Improvement Group for “check and challenge.”
3. The Improvement Plan will be presented to the QSE Committee for scrutiny. It was hoped a final version would be presented in January but as detailed above this is not possible and an interim plan is presented with a final to follow.

The five work-streams and leads are detailed below:

- Work stream 1 - Delivering Person Centred Care – Lead: Mandy Jones, Deputy Director of Nursing (confirmed on 30 December 2020)
- Work stream 2 - Dementia Quality Care – Lead: Tracey Williamson, Dementia Nurse Consultant
- Work stream 3 - Medicines Optimisation – Lead: Berwyn Owen, Chief Pharmacist
- Work stream 4 - Safeguarding and Escalation – Lead: Michelle Denwood, Associate Director of Safeguarding
- Work stream 5 – LLGH Actions – Lead: Trevor Hubbard, Area Director of Nursing

The membership of the Improvement Group is as follows:

- AHP Representative
- Associate Director of Nursing
- Associate Director of Quality Assurance (Chair)
- Associate Director of Safeguarding
- Community Health Council Representative
- Consultant Nurses for Dementia
- Local Authority Safeguarding Representative
- Medical Representative
- Nursing Representative/Area Nurse Director (Central)
- Patient/Carer Representatives - 2 Representatives
- Pharmacy Representative
- Staff Representatives - 2 Representatives
- Third Sector Representative - Age Cymru
- University Representative
- Work streams Leads if not already above

The Improvement Group has a role in scrutinising the proposed plan as outlined above, and also for scrutinising delivery as detailed below. The group consists of internal and external partners who have committed to supporting, guiding and challenging delivery of the actions and assurance of sustainability. The active involvement of external partners as equal members of the group will provide a strong “critical friend” forum to ensure actions are delivered and embedded.

The first meeting of the Improvement Group will take place in January 2022.

In terms of the monitoring and assurance process for the action plan, the following has been agreed:

1. Action owners will deliver actions in partnership with key stakeholders. Work stream leads will retain oversight and accountability for progress.
2. Corporate Quality Assurance will seek a bi-monthly update from all action owners using a pre-defined template - completed actions require evidence of completion and sustainability. This will be tracked via the Datix System.
3. The Improvement Group will meet bi-monthly to oversee progress, support action plan delivery and to validate evidence of action completion and sustainability by reviewing evidence presented to it by the action owner and work stream lead.
4. An update on delivery progress of the action plan will be presented bi-monthly to the Executive Delivery Group for Quality chaired by the Deputy Chief Executive. Escalation of concerns or delays will take place as needed.
5. A six monthly report will be provided to the QSE Committee based on the findings and recommendations of the Improvement Group through its scrutiny work.

Cefndir / Background:

Following concerns raised by student nurses into alleged poor clinical practice, poor patient experience and matters of safeguarding concern on Morfa Ward, the Executive Director of Nursing and Midwifery/Deputy CEO, commissioned a quality assurance review designed to provide the service with an honest and supportive assessment of quality with a focus on the following domains: safe care; effective care; dignified care; individual person centred care; staffing and leadership.

The review was presented to the QSE Committee in November 2021 by the review team.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered – Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – Contained within the analysis paper.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – Not applicable.

Asesiad Effaith / Impact Assessment – Not applicable.

Improvement Plan Summary following the Quality Assurance Review of Morfa Ward

Version 1.0

Note: a detailed improvement plan with current status and evidence is maintained for scrutiny by the Improvement Group

Recommendations for the LLGH Service				
Ref	Recommendation	Action	Responsible lead	Deadline
1.	LLGH nursing leadership to be strengthened, stabilised and supported for consistency and accountability with emphasis on compassionate and collective leadership.	1. Recruitment of Interim Ward Manager 2. Recruitment of Interim Matron 3. Daily Matron Walkabouts implemented 4. Monthly visits by Dementia Nurse Consultant (NC) 5. Ward Staff Meetings Re-established 6. Hospital Management Team meetings re-established <i>Cross-referenced to actions 2.1 and 2.2.</i>	Head of Nursing Head of Nursing Head of Nursing Dementia NC Ward Managers Matron	Completed Completed Completed January 2022 January 2022 January 2022
2.	Area Director of Nursing along with the Head of Nursing and Matron to provide enhanced frontline leadership visibility and engagement, fostering a culture of relationship focused leadership with staff, patients and families.	1. Twice weekly HoN/DHoN visits implemented 2. Visit schedule from Area Nurse Director planned	Head of Nursing Area Nurse Director	Completed January 2022
3.	Dementia Care Support Worker to be allocated consistently to the ward roster.	1. Recruitment to allow roster allocation 2. Review of funding to potentially extend provision	Matron Head of Nursing	Completed January 2022

4.	Standardisation of dementia-friendly crockery and utensils, dementia care signage, toilet seats and clocks to be introduced.	<ol style="list-style-type: none"> 1. Standardisation of crockery 2. Replacement of beakers/feeder cups across the site 3. Provide large face clocks 4. Provide dementia friendly toilet seats 	Matron Ward Managers Matron Matron	March 2022 January 2022 January 2022 January 2022
5.	Undertake a review of patient visibility within the ward lay out, identifying opportunities and adaptations to support bay nursing.	<ol style="list-style-type: none"> 1. Complete Kings Fund Dementia Friendly Audit Tool 2. Implement Baywatch SOP 3. Implement dementia friendly signage 4. Undertake estates review looking at visibility 5. Further actions will be detailed based on the outcome of the above review 	HoN/Dementia NC Matron Matron Matron	March 2022 January 2022 March 2022 January 2022
6.	A local nurse staffing risk assessment for the ward is required linked to the wider Area risk register and wider Corporate Nurse Staffing Risk. This provides the necessary detail for the Central Area Management Team to provide targeted intervention, mitigation, escalation and leadership support.	<ol style="list-style-type: none"> 1. Review of workforce and skill mix to be completed (to be completed across all community hospitals) 2. Placement Learning Environment Audit completed 3. Application of HR policy to address high sickness 4. Ward Clerks to be present for at least 8 hours per day 	Head of Nursing Matron/University Matron Service Manager	March 2022 February 2022 January 2022 February 2022
7.	Establish clear roles and lines of accountability for the management of risk on the ward needs to be reaffirmed and documented.	<ol style="list-style-type: none"> 1. Roles and lines of accountability to be reaffirmed 2. Ward risk assessment to be conducted 	Matron Matron	February 2022 January 2022

8.	Risk management refresher training is required for ward staff and the local leadership team to include clear ownership of process and accountability. This needs to dovetail with person centred care training. The use of Datix to support and record incident management requires training and educational support.	<ol style="list-style-type: none"> 1. Refresher risk management training provided to staff 2. Incident reporting training provided to staff 3. Staffing Red Flag reporting to be reemphasised 4. DoLS training to be provided <p><i>Cross-referenced to actions 1, 8 and 11</i></p>	Area Risk Manager Patient Safety Lead Matron Matron	January 2022 March 2022 January 2022 February 2022
9.	Indirect patient safety and quality activity/workload for example Datix reporting, quality auditing, nursing documentation is required to gain an understanding of its impact on care provision and for non-compliance with supportive corrective action.	<i>Cross-referenced to actions 8.1, 8.2, 1.4 and 1.5</i>		
10.	Safeguarding Ambassadors to be identified with assurance that attendance at the training is supported.	1. Recruitment and induction of 8 new ambassadors	Matron	January 2022
11.	The 'What Matters' and 'This is Me' documentation needs to be consistently monitored for completion supported with staff education and training.	<ol style="list-style-type: none"> 1. Incorporate checks in Monthly Matron Audits 2. Incorporate checks in Ward Manager Weekly Audits 3. Dementia Nurse Consultants will undertake case note reviews during monthly site visits 	Matron Ward Managers Dementia NC	January 2022 January 2022 January 2022
12.	Early and thorough patient assessment and care plan completion is required and needs reinforcing with supported staff education and training.	<i>Cross-referenced to 18.1, 11.1 and 11.2</i>		

13.	Ward Manager and Matron overseen by the Head of Nursing to maintain a robust schedule of quality audits with reporting and escalation through to the Area Quality and Safety Meeting.	<i>Cross-referenced to actions 1, 2 and 11</i>		
14.	Review ward organisation, communication and escalation with increased clinical engagement helping nurse leaders position themselves to facilitate greater collaboration and inquiry to support staff.	<i>Cross-referenced to actions 1, 2 and 11</i>		
15.	The Safeguarding Improvement Action plan agreed with the Hospital Nursing Leadership Teams for implementation to be closely monitored within the Area's quality reporting arrangements in addition to the Area Safeguarding Forums.	<i>The Safeguarding Action Plan is progressing with support from an identified safeguarding lead and scrutiny from the safeguarding governance structure and Director of Safeguarding and Public Protection</i>		
16.	Undertake a patient dependency, acuity and skill mix review with the potential to develop a workforce plan to modernise the workforce.	<i>Cross-referenced to action 6.1</i>		
17.	Review technology available to patients to provide meaningful occupation and connection with family and friends and technology used to manage risk (falls alarms).	<ol style="list-style-type: none"> 1. Training on family engagement provided 2. Staff identity board installed 3. "Hello my name is" badges ordered 4. Review of available technology 5. Further actions will be detailed based on the outcome of the above review 	Matron Dementia NC Matron Matron	February 2022 February 2022 February 2022 February 2022

18.	Provide stand-alone person centred care training for all clinical ward staff, to include promoting independence utilising a risk-based approach.	1. Training on person centred care provided 2. Training on MCA provided 3. Training on managing distressed staff provided	Dementia NC Matron Dementia NC	March 2022 Completed March 2022
19.	Criteria led discharge promoted to plan for patient discharge in partnership with the entire health care team, including the patient and/or their family carer.	<i>This action is still in development and will be finalised by end of January 2022.</i>		
20.	Further analysis and triangulation of information relating to repeated falls, pressure ulcers and repeated medication errors / omissions is required including training to identify if there are missed safeguarding opportunities within the reporting procedures.	1. All staff to undertake “back to basics” training 2. Escalation process for repeated medication refusals 3. Implement prescription handover sheet 4. Safety Thermometer audit to be consistently used	Matron Matron Matron Advanced NP	Complete Complete Complete February 2022

Recommendations for the Health Board				
Ref	Recommendation	Action	Responsible lead	Deadline
21.	A model of person centred care implemented throughout the Health Board to improve holistic assessment to inform the nursing process and enhance patient and family care experience.	<i>This action is still in development through co-design and will be finalised by end of January 2022.</i>	Deputy DoN	TBC

22.	Stand-alone person centred care training for all clinical staff to include promoting independence utilising a risk-based approach.	<i>This action is still in development through co-design and will be finalised by end of January 2022.</i>	Deputy DoN	TBC
23.	The introduction of Shared Governance as a framework to advance professional nursing practice, including a robust evaluation of the chosen model, which will support the drive for consistency of standards.	<ol style="list-style-type: none"> 1. Submission of a proposal to the Executive Director of Nursing and Midwifery on a Health Board wide shared governance model 2. Further actions will be detailed based on decisions made from the above proposal 	Dementia NC	January 2022
24.	Customer care and family engagement training for patient facing roles.	<ol style="list-style-type: none"> 1. A revised customer care training programme will be made available 	AD of Patient Experience	January 2022
25.	The 'What Matters' and 'This is Me' documentation needs to be consistently monitored for completion supported with staff education and training.	<i>This action is still in development through co-design and will be finalised by end of January 2022.</i>	Deputy DoN	TBC
26.	Early and thorough patient assessment and care plan completion is required and needs reinforcing with supported staff education and training.	<i>This action is still in development through co-design and will be finalised by end of January 2022.</i>	Deputy DoN	TBC
27.	Criteria led discharge is required to plan for patient discharge in partnership with the health care team, including the patient and/or their carer.	<i>This action is still in development through co-design and will be finalised by end of January 2022.</i>	Deputy DoN	TBC

28.	Good practice and learning identified during this review to be communicated and celebrated.	<i>This action is still in development through co-design and will be finalised by end of January 2022.</i>	Deputy DoN	TBC
29.	Standardisation of dementia-friendly crockery and utensils	1. Dementia Nurse Consultants to work with Dementia Support Workers to review provision across all sites and order appropriate dementia-friendly crockery and utensils as needed	Dementia NC	February 2022
30.	Dementia training refreshed, designed to deliver to staff in patient-facing roles.	1. Dementia training to be refreshed and available for delivery to staff	Dementia NC	January 2022
31.	Awareness raising to understand distressed behaviours expressed in people living with dementia and change use of powerful and stigmatising language. This to include the avoidance of the terms 'violent' or 'aggressive' to a more positive person-centred language.	<i>Cross-referenced to action 30.1</i> 1. Review use of terminology in policy and guidance documentation.	Dementia NC	March 2022
32.	A review of the Dementia Support Worker resource and parity in its provision needs undertaking alongside provision of a Health Board network for role-holders.	1. Create a network of Dementia Support Workers 2. Organise independent scoping of provision 3. Further actions will be detailed based the above scoping	Dementia NC Dementia NC	January 2022 April 2022
33.	Dementia Champion roles refreshed and increased in number.	1. Create a directory of champions 2. Co-design training needs with champions 3. Further actions will be detailed based on decisions made from the above training needs review	Dementia NC Dementia NC	March 2022 March 2022

34.	Wards need to repeat King's Fund Dementia Friendly Environments audits previously undertaken in 2017.	<ol style="list-style-type: none"> 1. Undertake reviews on all sites and collate findings 2. Further actions will be detailed based on decisions made from the above training needs review 	Dementia NC	May 2022
35.	Options to enhance the built ward environments/patient visibility within wards. These need appraising along with options for developing outdoor 'dementia friendly' space for patients where these are absent.	<i>Cross-referenced to action 34.1 and 34.2.</i>		
36.	Standardisation of dementia care signage, toilet seats and clocks.	<ol style="list-style-type: none"> 1. Dementia Nurse Consultants to work with Dementia Support Workers to review provision across all sites and order appropriate dementia-friendly signage, toilet seats and clocks. 	Dementia NC	July 2022
37.	A review of technology available to patients to provide meaningful occupation and connection with family and friends and technology used to manage risk (falls alarms).	<ol style="list-style-type: none"> 1. Dementia Nurse Consultants to work with Dementia Support Workers to review provision across all sites and order appropriate dementia-friendly technology 	Dementia NC	May 2022
38.	Commission an in-depth review to establish the actions taken to manage medication omission and organisation wide learning.	<ol style="list-style-type: none"> 1. A paper is being taken to the QSE Committee in January 2022 outlining medication incident reporting. 2. Medication incident reporting will be a key work-stream of the roll-out of the new Datix incident module via training 	Executive MD AD of Patient Safety	January 2022 April 2022

39.	Health Board to work with the Universities to ensure the Escalation of Concerns Process incorporates direct escalation to the Executive Nurse Director and Midwifery alongside the escalation to the Associate Nurse Director Regulation and Education.	1. Escalation arrangements confirmed with University partners.	AD of Nursing Education	Completed
40.	Internal professional escalation to the Executive Nurse Director to be strengthened and reinforced.	1. Professional escalation to be clarified and documented in a clear process 2. Incident Policy and Procedure to be revised and updated including clarity on escalation	AD of Safeguarding AD of Patient Safety	January 2022 April 2022



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience Committee 11 January 2021					
Cyhoeddus neu Breifat: Public or Private:	Public					
Teitl yr Adroddiad Report Title:	Medication Incident Reporting					
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons Executive Medical Director					
Awdur yr Adroddiad Report Author:	Dr Berwyn Owen, Chief Pharmacist Louise Howard-Baker, Assistant Director Pharmacy & Medicines Management (East) Judith Green, Medication Safety Officer/ Governance Pharmacist – Policies					
Craffu blaenorol: Prior Scrutiny:	AAA Report presented to PSQG 12.10.21					
Atodiadau Appendices:	Presentation Attached					
Argymhelliad / Recommendation:						
The Quality, Safety and Experience Committee is asked to note the current position with regards to medication related harm.						
Ticiwch fel bo'n briodol / Please tick as appropriate						
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						✓
						No. SEIA relates to strategic decision. This paper is an update. Therefore not required
Sefyllfa / Situation:						
The under-reporting and subjective scoring of medication-related incidents currently conveys an inaccurate level of harm within BCUHB. This paper explores the current position and provides a summary of the issues associated with medication-related harm for those medicines prescribed, dispensed and administered within BCUHB healthcare settings.						
Cefndir / Background:						
Reporting levels of medication incidents						
Based on evidence ¹ , in 2015, in one year, in an average acute hospital, approximately 0.5 million prescriptions were written and 2.5 million doses of medicine were administered. Based on this data and the evidenced error rate, BCUHB would expect annually to have approximately:						

¹ [How the new network of NHS Medication Safety Officers and Medical Device Safety Officers are affecting patient safety](#) 9th December 2015 Dr David Gerrett Senior Pharmacist Patient Safety NHS England

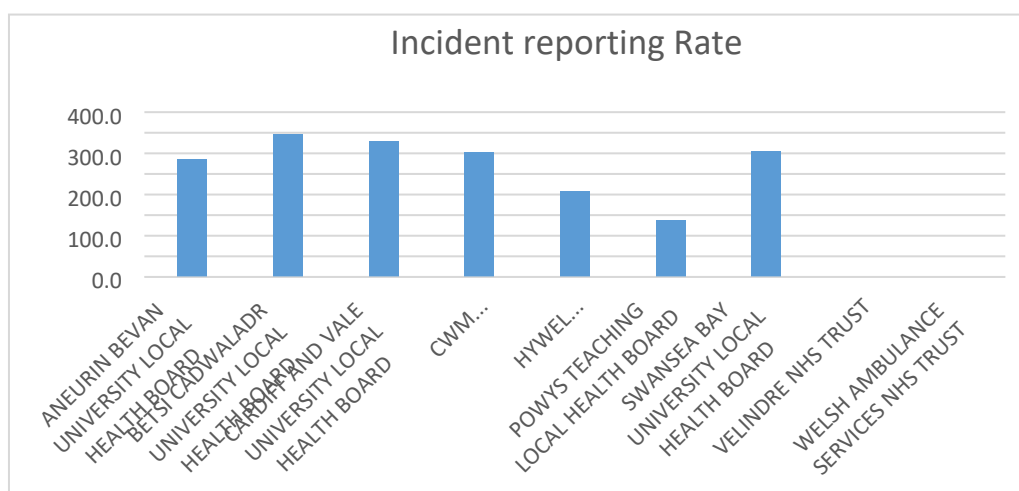
- 645,000 administration errors
- 135,000 prescribing errors, of which 1,650 are potentially fatal
- 120-300 dispensing errors.

Of these, 757,000 (97%) would result in no or low patient harm.

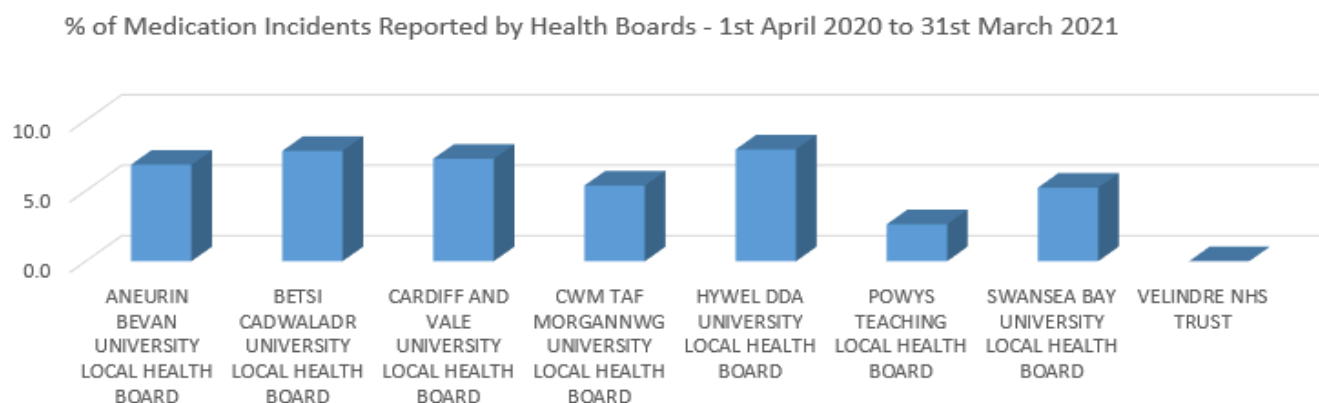
In reality, just 1,755 (0.2% of expected) medication incidents were reported in the 12 months to September 21, of which 1709 (97%) were scored as resulting in no or low harm.

A 'low' reporting rate from an organisation should not be interpreted as a 'safe' organisation and may represent under-reporting. Subsequently, a 'high' reporting rate should not be interpreted as an 'unsafe' organisation, and may actually represent a culture of greater openness.

Of some reassurance, is that BCUHB has a better overall incident-reporting rate than other health boards in Wales. Rates are calculated as the number of reported incidents divided by the number of bed days.



BCUHB data also shows that the percentage of medication incidents reported is also higher than most other health boards:



The bulk of prescribing actually takes place in primary care, with 17.7 million prescriptions issued in BCUHB in the 12 months to July 2021. Prescribing and prescription errors occur in up to 11% of all prescriptions, mainly related to dosage. A quarter of patients will experience an adverse event within four weeks of starting a medicine, of which 11% are preventable. These largely go unreported. Community pharmacies are only obliged to report controlled drug incidents to BCUHB and have their own incident reporting systems, which feed into the National Learning and Reporting System (NRLS).

The reasons medication incidents are not reported include:

- a) Prescribing errors are picked up and corrected by either pharmacy or ward staff before administration.
- b) Processes are already implemented to prevent an administration error e.g. an independent second check by another health professional for high-risk medicines.
- c) Reporting of medication incidents is not mandated unlike healthcare acquired pressure ulcers (HAPU), healthcare acquired infections (HCAI) and falls, which until June 2021, had to be recorded on Datix, so these areas of harm account for higher reporting rates.
- d) Many incidents resulting in a fall or a health care acquired infection (HCAI) such as *C. difficile* may be reported as the consequence (the fall) rather than the root cause (the medicine causing e.g. a sudden drop in blood pressure).
- e) Well recognised barriers to reporting:
 - Lack of time to report;
 - Access to computers to report;
 - Complicated and long e-forms to complete;
 - Little or no feedback received by reporter, so they see no gain from reporting;
 - Fear of repercussions of reporting;
 - Lack of training of how and what to report;
 - Use of incident reporting as a form of punishment: 'I will Datix you!'

The high reported rates of low or no harm may be a misunderstanding by staff of the harm potential even when an intervention has been required such as an antidote or increased monitoring. The vast majority of incidents are near misses, but they do provide extensive opportunities for learning. See Appendix 1 for recent examples.

Strategy

Safer Medicines Steering Group

The Safer Medicines Steering Group (SMSG) reinstated after a temporary pause during Covid-19 and following the step down of the previous Chair, has been meeting monthly since July 2021. The revised Group is still in its infancy and will use reports from the three local Safer Medicines Practice Groups (SMPGs) to identify new areas of risk and assume a role in overseeing and monitoring their mitigation and the implementation of improvements on a pan-BCU basis.

The group will concentrate primarily on a small, but key number of areas identified from analysis of incident and pharmacist intervention data. These are:

- Reducing missed doses, in particular those relating to critical medicines
- Junior doctor medicines management education at induction and ongoing
- Methotrexate incidents
- Insulin incidents

Other wider issues of training, digital solutions (e.g. clinical guidance app) and managing prescribing incident processes will become the focus once progress can be demonstrated in these initial areas.

New developments including the Once for Wales incident reporting system and electronic prescribing, will offer opportunities to use reporting tools to encourage a change of culture through early reflective learning aim of promoting safe and prudent prescribing thereby reducing avoidable harm to patients.

Learning from Errors

"Properly instituted learning cultures have transformed the performance of hospitals around the world." Black Box Thinking; Matthey Syed

There are new daily reviews of major and catastrophic incidents and site and area Make it Safe meetings. Attended by governance nurses and pharmacy staff, who support the investigations and learning from administration errors. As a result they have produced some resources including competence frameworks and You Tube videos for second checking for high risk medication and human factors;

Current systems do not lend to prescribers learning from their errors resulting in poor prescribing standards and potential patient harm. Barriers are multifactorial and include;

- Identifying the prescriber from the hand written prescription chart.
- No formal process to feed back incidents to the prescriber or their consultant.
- Senior engagement and time commitment to manage reported incidents.
- Assurance that improvement/learning has taken place post incident.
- Obtaining feedback or reflection from prescriber involved (fear of reprisal/litigation).
- BCU-wide process for shared learning.

An in-depth prescribing audit by pharmacy teams is planned for January /February 2021 to gain more understanding of the types of prescribing errors in acute and community hospital wards, which will support education for clinicians.

Structure

The planned new clinician-led operating structure offers an opportunity at both health board and at health economy level to raise the profile of medicines management-related issues and drive improvements across all sectors.

Systems

Digitalisation – Hospital E-prescribing and medicines administration (HePMA)

The benefits of HePMA are well documented and demonstrate amongst other things, a significant reduction in medication-related errors. High-risk medication errors can be reduced by more than 50%. The benefits of having an audit trail mean that it is possible to use data to support learning for professions involved with prescribing, clinical checking and administration. They are challenging to implement and require significant change to working practices across medicine, nursing and pharmacy.

Once for Wales Reporting System (formerly Datix)

The quality of the information provided in incident reports is frequently extremely poor and so there are missed opportunities for learning. The implementation of a new incident reporting system in the first quarter of 2022/23 provides BCU HB with an opportunity to drive improvement. Its success will require training of staff to promote the key messages:

- Why it is important to report incidents
- How to report an incident (talk through the form)
- How to score the potential harm;
- Where appropriate, the investigation of incidents

Sharing good practice and feedback to reporters will be important to realise the benefits and increase confidence in reporting. Pharmacy and Medicines Management with the direction of the Safer Medicines Steering group will continue to analyse, monitoring the themes to facilitate learning and drive improvement.

Clinical Guidelines

Clinical practice guidelines should support clinicians and patients to make prudent decisions about appropriate healthcare for specific clinical circumstances. But:

- There are insufficient and in date guidelines available on the intranet to support junior prescribers and they are virtually impossible to find.
- Developed guidelines may not be readily available, but located on specialist sites with password-protected access.

- There are local and regional variations in practices/ guidelines.
- There is a lack of assurance of compliance with guidance.

The new intranet, due for launch in April 2022 provides an opportunity to make key clinical information readily available to access on any device.

Skills

Education and Training

Medical Staff

Although a medical undergraduate training programme is in place, there is no process in place to ensure qualified prescribers receive ongoing mandatory medicines management training. There is also variance in the induction programmes offered to newly qualified doctors across the three sites. This is one of the areas identified for improvement by the Safer Medicines Steering Group.

A framework is being developed to extend the practice of health professionals to allow certain prescriber tasks e.g. transcribing of medicines charts to be undertaken. This would take some pressure of time-challenged medical prescribers.

Nursing Staff

Mandatory medicines management training is a requirement for nurses, but because it does not appear in the competency matrix on ESR, compliance is difficult to monitor. A comprehensive ongoing training programme is in place for registered nurses e.g. Back to Basics, IV training. Bespoke 1:1 training is offered to individuals to support individuals with ongoing issues when resources allow.

Staff

Pharmacy & Medicines Management have previously highlighted a number of risks to the BCUHB QSE about competing service priorities, which are pressurising clinical services. There has been some welcome investment into mental health and learning disabilities, cancer services, vaccination, wholesale dealing. There is also a commitment to support drug library development for intravenous pumps, which will improve medicines safety.

Although the service will continue to seek investment to cover unfunded areas and influence future business cases, there is a commitment to ensure that all staff are working to the top of their licence. Non-essential work, such as redirecting outpatient prescriptions so that staff can undertake their clinical duties on the wards to improve medicines safety where it is most likely to fail i.e. on admission, transfers and discharge.

Style

Medicines Management is a multidisciplinary responsibility across all healthcare professionals. The use of medicines is the most common intervention in patient care. Medication errors can have consequences that can be catastrophic for patients including death, significant organ failure or long-term impact on quality of life. To improve the culture of medication safety within the health board requires strong leadership from all professions, not the interested few to try to implement change that is impossible to sustain without commitment and resource. The Safer Medicines Steering Group has the will but the Safe Medication Practice Groups need both will and commitment at ward manager, matron, consultant, directorate and director level to effect a lasting change.

Creating a positive culture around medication safety is key to empowering staff to report incidents and hence learn lessons to prevent future harm. The paediatric and neonatal service at YGC is an example of how this can be achieved. The consultant has created a positive safety environment where all staff are encouraged to report even the smallest error. The high level of reporting is indicative of safe and high quality care, staff use reporting to celebrate high quality care as well as errors. A weekly review of incidents and action plans are integral to the process. The key to success lies with effective leadership and commitment to the medication safety agenda.

Dadansoddiad Risk / Risk Analysis
Cyfreithiol a Chydymffurfiaeth / Legal and Compliance
Asesiad Effaith / Impact Assessment This is purely an administrative report to update and inform the Committee on the medication related harm. The report does not have a negative impact on equality, socio economic disadvantage or human rights beyond what is highlighted in the risks identified.

Appendix 1

Medicines Management is the term that encompasses the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care. Never before has there been a time when medicines have been at the forefront of patient care for tackling a major pandemic in the form of both prevention (vaccine) and treatment for patients with Covid-19. Medicines are therefore the responsibility of everyone involved with their use.

1. Defining Medication-related harm

Medication-related harm happens a result of any or many factors including:

- The prescription or administration of wrong medication,
- Wrong dosage/route/frequency,
- Wrong patient,
- Failure or delay of drug treatment (e.g. failure to give prophylactic care or immediate treatment for sepsis)
- Failure to monitor
- Failure to discontinue medication.
- Failure to remove faulty or discontinued products.

Other factors can increase a patient's susceptibility to harm. 20% of patients over 70 years old take five or more medicines. With multiple medical conditions, the likelihood of more medicines being prescribed increases, sometimes to counteract side effects of existing treatment. In addition as ageing occurs, the ability for the body to handle medicines alters and can result in medicine overload and toxicity and patient harm:

Absorption	Decreased gastric acid alters absorption of those drugs affected by acid/alkaline environment. Decreased gastric mobility can increase absorption of others because they remain in the stomach longer.
Distribution	A decrease in Total Body Water and lean body mass so water soluble drugs have less volume for distribution causing increased serum concentrations; Increased body fat so lipid soluble drugs accumulate which prolongs their duration of action
Metabolism	Increased drug effects because of reduced liver metabolism and diminished enzyme activity.
Excretion	The kidneys become less efficient with age and as they are one of the main routes for excreting drugs or their metabolites, this can lead to accumulation and even further damage to the kidneys.

2. Scoring Harm when reporting Incidents

The National Learning and Reporting System uses the following definitions for the degree of harm:

- **Negligible** – a situation where no harm occurred: either a prevented patient safety incident or a no harm incident
- **Minor** – any unexpected or unintended incident that required extra observation or minor treatment and caused minimal harm to one or more persons

- **Moderate** – any unexpected or unintended incident that resulted in further treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused short-term harm to one or more persons
- **Major**– any unexpected or unintended incident that caused permanent or long-term harm to one or more persons
- **Catastrophic** – any unexpected or unintended event that caused the death of one or more persons.

It is widely acknowledged that scoring of incidents is subjective. However, there is a clear lack of understanding by reporters and incident handlers in attributing risk scores in terms of both actual harm experience and the potential for harm. The implementation of the new 'Once for Wales' incident reporting module will simplify the process to categorise harm but there is an immediate need for education to ensure harm is reported and therefore documented correctly by all healthcare staff. Incidents scored inappropriately are at risk of not being fully investigated and candour not applied.

Serious medicine related errors may come to light when patients are admitted to hospital or access other services.

All examples are taken from September 2021 Datix reports.

Example: The ambulance service were called to review an unwell patient after she had taken quetiapine, an antipsychotic (extremely large dose) which had been dispensed instead of the intended quinine (for cramp) by a community pharmacy. An admission was avoided but the patient was advised to see their GP as soon as possible.

Score: Negligible harm.

Example: A patient at risk of developing a thromboembolism was inappropriately sent home with a supply of the injections received during their admission. Their GP practice received a call from a patient asking about the injections which were not on the discharge letter. Upon investigation, it became apparent that the patient had been sent to the discharge lounge without the discharge prescription being written or checked by ward staff. This was a near miss, the injections were stopped and the patient informed of the error.

Score: Negligible harm

3. Omissions

It is well recognised that omitted or delayed administration of critical medicines during a hospital admission can cause harm. Patients with Parkinson's disease are another example of patients at high risk of harm from omitted medicines, they require strict adherence to their individualised timed medication regime. Delaying medications can cause worsening tremors, increased rigidity, loss of balance, confusion, agitation, and difficulty communicating

Example: A patient alerted nursing staff that they had not had their antiepileptic medicines since admission and warned them of an impending seizure and consequently suffered a seizure. This was preventable had the medicines been prescribed and administered.

Score: Negligible harm

Example: A patient did not have their rotigotine patches for Parkinson's disease prescribed on admission. It was noticed and addressed, but by this time the patient was rigid.

Score: Negligible harm

4. Prescribing

Prescribing in primary care accounts for many incidents of harm, some of which result in medication-related admissions and many preventable. Pirmohamed² found that admissions due to medicines harm were accountable for 6.5% of all admissions. The table below shows the number of bed days taken with these patients in Welsh Hospitals. However, approximately 90% of expected BCUHB medication-related admissions are not captured through clinical coding.

	2016/17	2017/18
Medication Related Admissions - Bed Day	Total MRA Bed Days	Total MRA Bed Days
Abertawe Bro Morgannwg University	8163	6247
Aneurin Bevan University	7590	7094
Betsi Cadwaladr University	11789	8884
Cardiff and Vale University	9040	8445
Cwm Taf University	4597	4583
Hywel Dda University	5304	5008
Powys Teaching	1036	1112
Velindre	1021	842
All Wales	48540	42215

Prescribing errors most commonly occur at interfaces e.g. admission, discharge or transfers. On admission to hospital, pharmacy staff correct any errors/discrepancies as part of their medicines reconciliation process. Out of hours, or if patients are admitted to wards where there is no pharmacy cover, the errors may be picked up by nurses during administration rounds, and may then result in delayed or omitted administration, while they wait for the prescription to be corrected, or the error may remain undetected. The risk is that if critical medicines are missed from the prescription, then patient harm will occur.

For newly discharged patients there is a discharge medicines review (DMR) service, conducted by community pharmacists to reconcile medicines pre and post admission to prevent any errors (e.g. restarting discontinued medicines).

With no electronic prescribing system in place, a systems mitigation of human errors is a challenge. The following examples could have been prevented with a system in place.

Example: A patient was prescribed and administered a dose of pregabalin (a medicine used for both epilepsy and neuropathic pain) which was four and a half times the intended dose. The patient was excessively drowsy the next morning.

Score: Negligible harm

The accurate **recording of allergies** on the treatment chart is very important and again without the use of electronic systems there is a risk that patients will be prescribed medicines to which they have a known allergy.

Example: A patient was given intravenous paracetamol in theatre despite the allergy to paracetamol being document on the chart.

The patient required oxygen, intravenous antihistamine and intravenous steroids.

² Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. MJ 2004;329:15

Score: Negligible harm

Omitting a medicine can also be a source of avoidable harm.

A patient attended a follow-up orthopaedics outpatient clinic, and it was identified that they had not been prescribed enoxaparin to prevent a thromboembolism when they were discharged from hospital. As they had a below knee non weight bearing cast they were at risk of developing a thromboembolism.

Score: Negligible harm

5. Administration

Errors associated with intravenous medicines carry a high risk if incorrectly administered.

Example: The infusion for an antiarrhythmic drug, amiodarone was set up to run over 24 hours. After two hours it was noticed that the rate of the infusion was ten times the intended rate. IV amiodarone given too rapidly can cause anaphylactic shock, sweating and nausea.

Score: Near miss with intervention

Quality, Safety & Experience Committee

January 2022

Medication Incident Reporting/ item

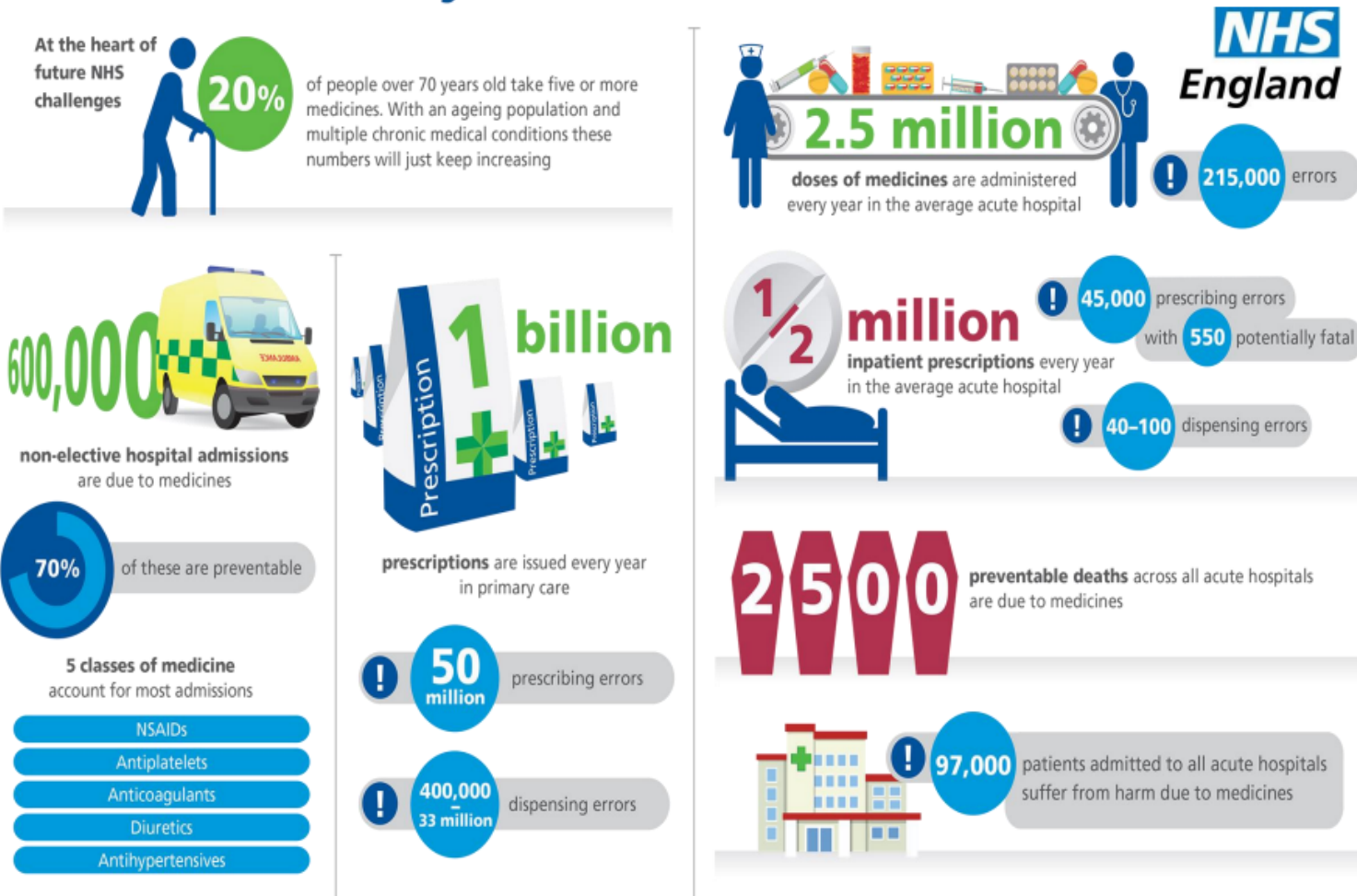


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University Health Board

Medication Safety – Burden on healthcare systems

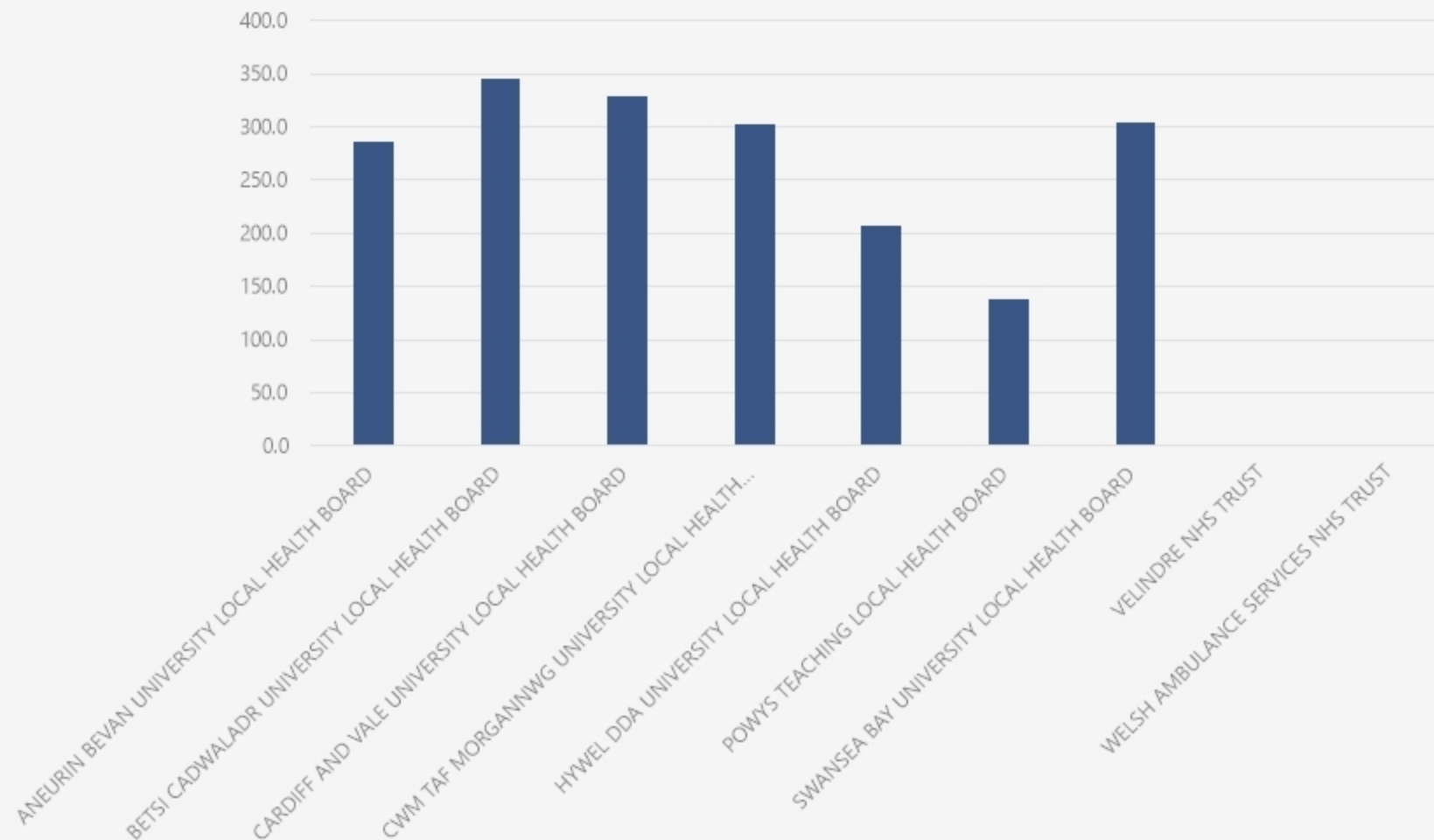
Medication safety in the NHS



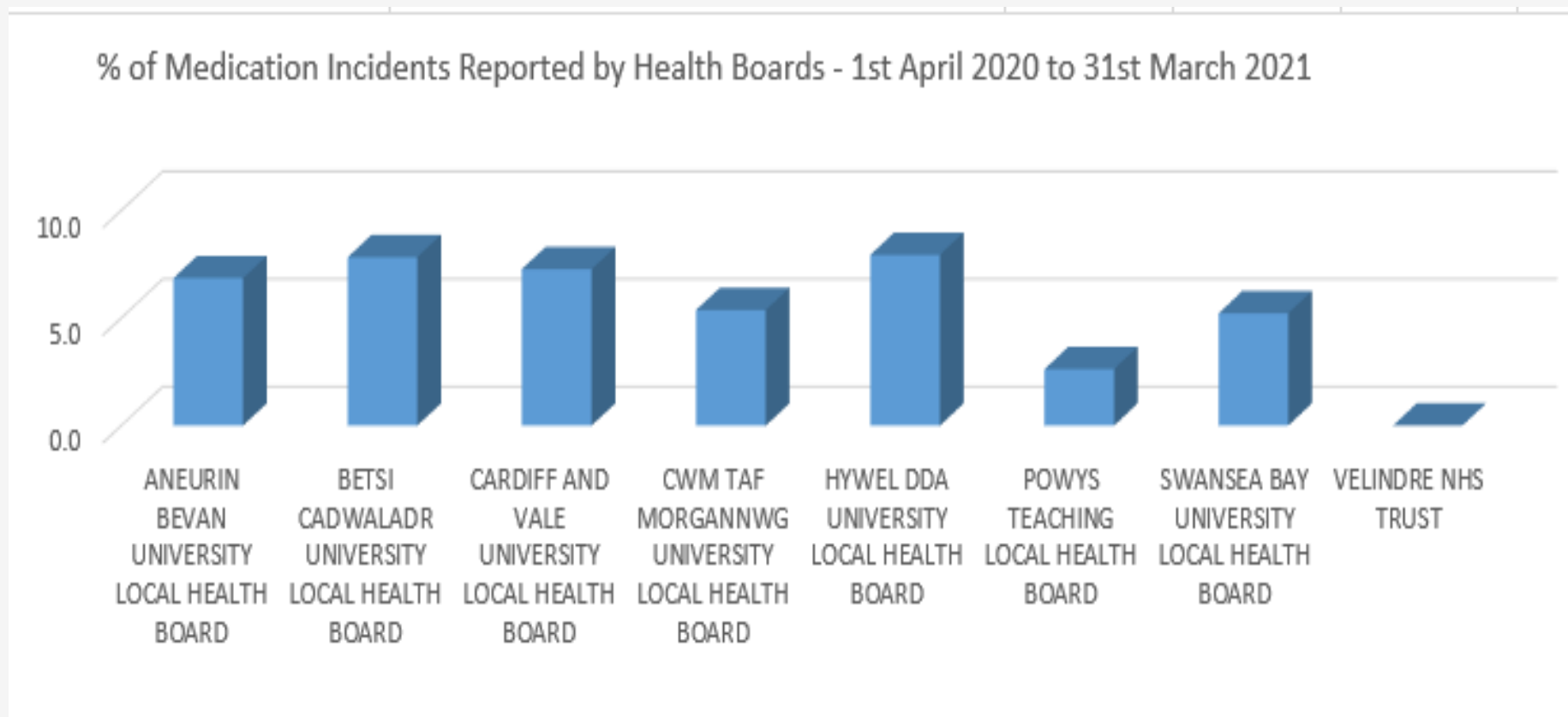
97% of medication errors reported to the NHS result in no or low patient harm

Health Board Reported incidents/per bed days

Incident Reporting Rate April 2020 – March 2021



Medication incidents as proportion of all reported incidents



Location of Incidents

BCU Area/Region	Number of Incidents reported September 2021
Secondary Care Acute Wards/Clinical Areas	81
Primary Care and Community Services (Area)*	42
Children and Young People (Area)	14
Division of Mental Health and Learning Disabilities	12
Pharmacy and Medicines Management (Area)	11
Cancer Services (Secondary)	5
Women's and Maternal Care (Secondary)	5
Anaesthetics, Critical Care and Pain Management (Secondary)	3
Radiology (Secondary)	1
Public Health (Corporate)	1
Grand Total	175

*Covers community nursing, community hospitals, GP practices, community pharmacies

Medication Safety



Diolch
Thank you



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Betsi Cadwaladr
University Health Board

Cyfarfod a dyddiad: Meeting and date:	Quality & Safety Committee 11 January 2022
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Health and Safety 2021/22 Quarter 1 and Quarter 2 Report
Cyfarwyddwr Cyfrifol: Responsible Director:	Sue Green, Executive Director of Workforce and Organisational Development
Awdur yr Adroddiad Report Author:	Pete Bohan, Associate Director of Health, Safety and Equality Sue Morgan, Head of Health and Safety
Craffu blaenorol: Prior Scrutiny:	<i>Strategic Occupational Health & Safety Group 2 November 2021</i>
Atodiadau Appendices:	Appendix 1 – Q1 Health and Safety Snapshot Appendix 2 – Q2 Health and Safety Snapshot

Argymhelliad / Recommendation:

The Committee is asked to note the position for the first 6 months of 2021/22 and the progress made in respect of Health, Safety and Security.

The report also contains an update on work being undertaken for Lone Working and an update following the Inspection by the Health and Safety Executive in November 2021.

Please tick as appropriate

Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	<input type="checkbox"/>	Ar gyfer Trafodaeth For Discussion	<input type="checkbox"/>	Ar gyfer sicrwydd For Assurance	<input checked="" type="checkbox"/>	Er gwybodaeth For Information	<input type="checkbox"/>
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Sefyllfa / Situation:

The combined Quarter 1 and Quarter 2 report provides an update on the work undertaken by the Corporate Health and Safety (H&S) Team during the period between the 1st of April 2021 to the 30th of September 2021. The Annual Report for the year 2020/2021, considered by this Committee and subsequently by the Health Board in July 2021, identified that whilst some progress had been made, many elements of the implementation of the Health and Safety (H&S) Strategic Improvement Plan had been delayed. The primary reason for this was as a result of Covid 19 and the significant amount of work undertaken managing and reporting RIDDOR and ensuring Covid safe environments were effectively managed throughout the pandemic.

Cefndir / Background:

The Strategic Health & Safety Gap analysis against legislative requirements undertaken in September 2019 identified significant areas of concern in the management of OHS within BCUHB. The OHS Team developed a comprehensive 3-year Improvement plan to identify and mitigate the risks identified. This Improvement plan included key areas of risk such as contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security, violence and aggression (V&A), fire, electrical safety, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. A review by the H&S Team of key risk areas including water safety, asbestos and electrical safety has supported the Estates Department in re-establishing specific groups that monitor the outcomes of the reports provided. The significant risks have been

escalated through the risk register and Board Assurance Framework to support BCUHB achieve full compliance with legislative requirements.

Asesiad / Assessment & Analysis

Strategy Implications

BCUHB will be required to implement the remaining 2-years of the Improvement Plan . The focus is on identifying and wherever practicable, eliminating or minimising hazards based on the HSE Safety Management System HSG65 and principles of Plan, Do, Check, Act. The process described in the Plan will not only help to reduce the likelihood of accidents and ill health. It will also help to improve time for staff to give care to patients, help to reduce financial waste and improve the quality of care and quality outcomes given to clinical services and non-clinical support services. The 2-year plan is based upon credible data from a variety of sources to identify the need for change. Similarly, quality improvement methodology will be utilised to enable change. The changes outlined in this report due to the COVID-19 pandemic will impact on achieving the OHS Improvement Plan.

Options considered

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

Financial implications

There are no specific financial implications arising directly from this report. Significant investment has been approved through the Executive Team and endorsed by the Executive Director of Finance with appropriate sources of funding identified and agreed. The programmes of work against this investment are set out within the Integrated medium Term Plan 2022 – 2025. Whilst further realignment of expenditure is likely to be required to correct longstanding issues (all documented through the Health Boards Risk structure), the impact of the investment agreed in 2021 will be considerable in enabling progress against the improvement plan.

Risk analysis

The significant risks have been escalated to the Board Assurance Framework and on the tier 1 risk register and were previously agreed by QSE. These include Leadership of OHS, Security, Contractor Management and Control, Asbestos, Legionella and Fire Safety. These risks were initially added onto the risk register under the Corporate Health and Safety Team and a number have now been added to the Estates/facilities risk register as they hold the responsibility for the management of these risks.

Legal and compliance

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

Impact Assessment

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

1. Health and Safety Team Snapshot for Quarter 1

A snapshot of the team activity for both Q1 and Q2 can be found in appendices A and B

2. Health and Safety Gap Analysis Action Plan

The work on the full gap analysis improvement plan was put on hold at the start of the COVID-19 pandemic. This was slowly restarted in Q1/2021/22 when a Health and Safety workshop with key partners across the organisation, was held to recommence the work required to ensure compliance with H&S legislation. With support from additional dedicated H&S resource, a full review has been completed in the areas of Water Safety, Electrical Safety and Asbestos Management. In Q2/2021/22, the Management of Pressure Systems report was completed and monitoring against this action plan from this report is now a standing agenda item on the Pan BCUHB Estates H&S Meeting.

3. Corporate Health and Safety Team Site Visits 'social distancing and staying safe' programme

With the onset of the Coronavirus (COVID-19) pandemic in March 2020 the H&S team stopped undertaking routine site visits until the Welsh Government restrictions were updated. The team commenced site visits on request to support with the 'social distancing and staying safe' programme. This programme was put in place to support managers in assessing the social distancing requirements in their areas of control and to assist with the risk assessments for staff at high risk and Clinically Extremely Vulnerable from COVID -19. This program of visits remains in place.

In the 2020/21 year, a total of 431 visits were undertaken. In Q1 of 2021/22 a further 84 visits were undertaken with a further 73 in Q2. The visits are measured as KPI's for the team with the requirement to undertake a visit within 2 weeks of the request. This has been achieved consistently throughout Q2.

4. Corporate H&S reviews

Corporate Health and Safety reviews are required under the BCUHB Health and Safety Policy as part of the mandatory requirement to monitor H&S compliance. These reviews were put on hold in March 2020 and later reintroduced on a small scale in 2020/21 with a total of 82 completed in the first 2 quarters.

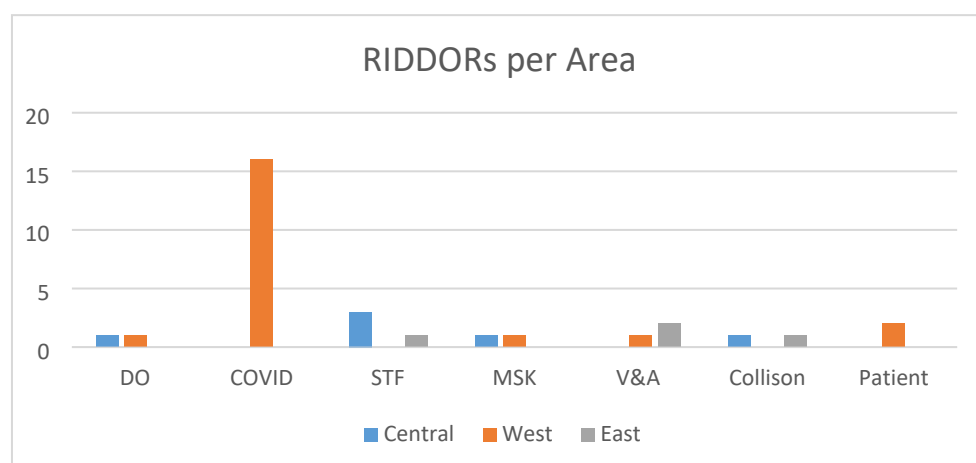
In Q1 of 2021/22 49 reviews were completed, with a further 31 reviews completed in Q2. A review report is provided to managers to support with ensuring H&S compliance. The Corporate H&S reviews are a team KPI and this target was achieved in Q1. However, in Q2 the social distancing and staying safe program took priority with the changes to Alert Level Zero on the 7th of August 2021. This was to support the safe return to work, where possible, of staff identified as being at high risk and Clinically Extremely Vulnerable from COVID-19.

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

With effective COVID-19 management in clinical and non-clinical settings, together with a high uptake of the COVID-19 vaccine by staff, a marked decrease was seen in Q1 in the number of occupational disease reports that were made to the HSE under RIDDOR. This was further evidenced in Q2 with only 3 occupational disease reports being made to the HSE under RIDDOR, for a small staff cluster in Central. Despite two further COVID-19 Outbreaks being declared, in both West and Central, no work-related transmission of COVID-19 to staff has been identified.

A total of 35 RIDDOR reports were made to the HSE in Q1. These break down into:

- 2 Dangerous Occurrences (1 fire-related, 1 overturned hoist)
- 28 incidents involving staff: 16 COVID-19 related; 4 slip, trip & falls incidents, 3 violence and aggressions incidents, 2 musculoskeletal injuries, 3 collisions with equipment
- 5 Patient related falls with Specified Injury.

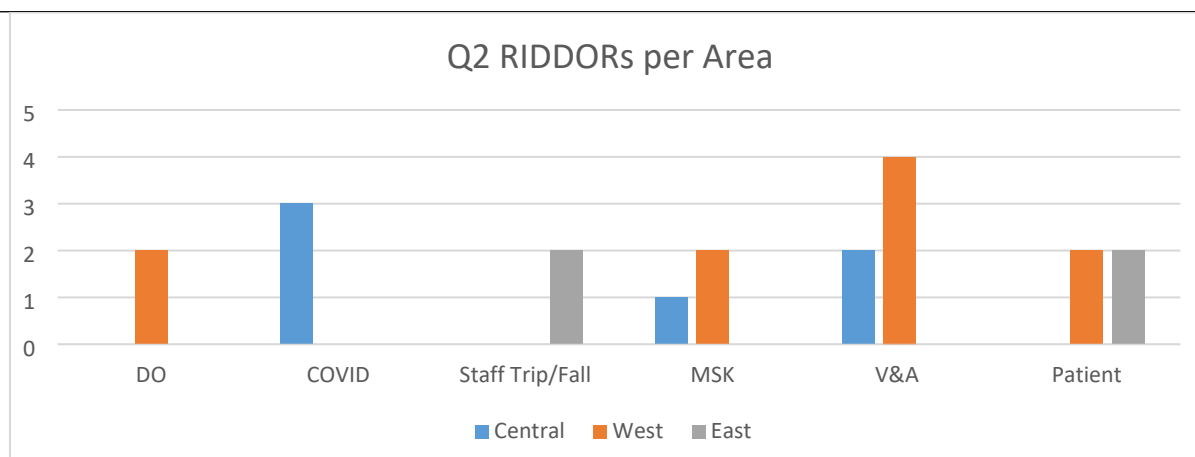


A total of 20 RIDDOR reports were made to the HSE in Q2. These break down into:

- 16 incidents involving staff: 2 Needle-stick injuries reported as Dangerous Occurrences, 6 violence and aggression incidents, 3 musculoskeletal injuries, 2 slip, trip and fall incidents and 3 occupational acquired COVID-19.
- 4 patient related falls with Specified Injury

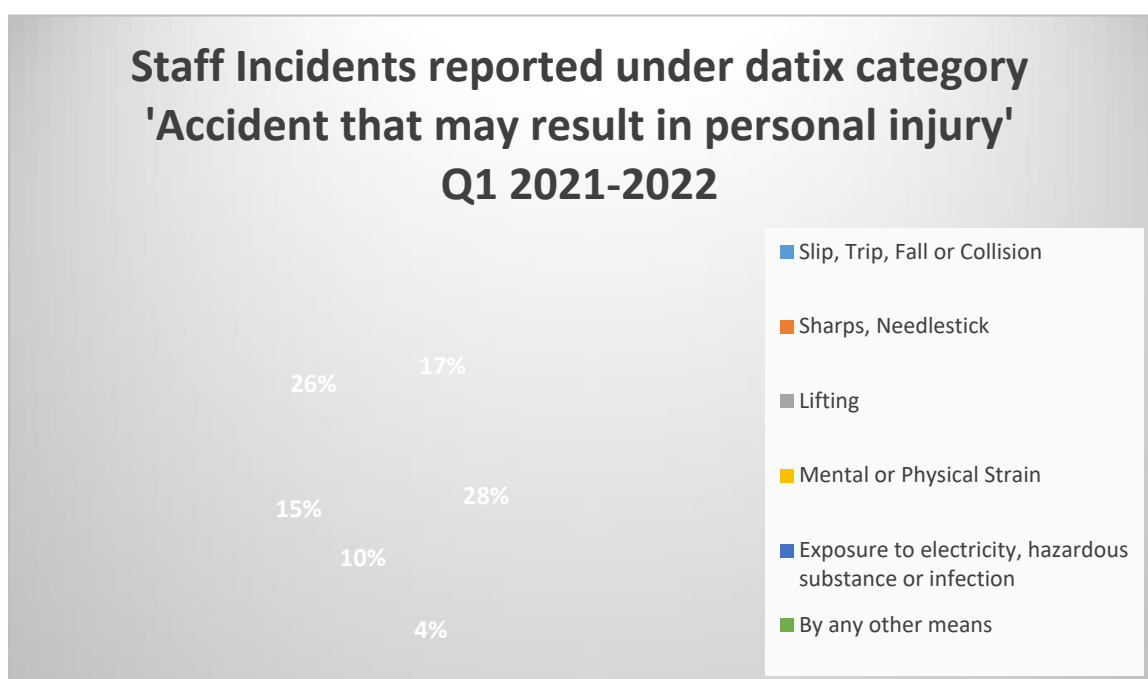
A comparison of the RIDDOR's reported in Q2 2020 and Q2 2021 is below and evidences the significant reduction in COVID-19 related RIDDOR's reported this quarter.

Area	COVID -19 RIDDORs Q2 2020	COVID-19 RIDDORs Q2 2021	Non COVID RIDDORs Q2 2020	Non COVID RIDDORs Q2 2021	Total Q2 2020	Total Q2 2021
Central	51	3	9	3	60	6
West	83	0	9	10	92	10
East	144	0	2	4	146	4
Totals	278	3	20	17	298	20



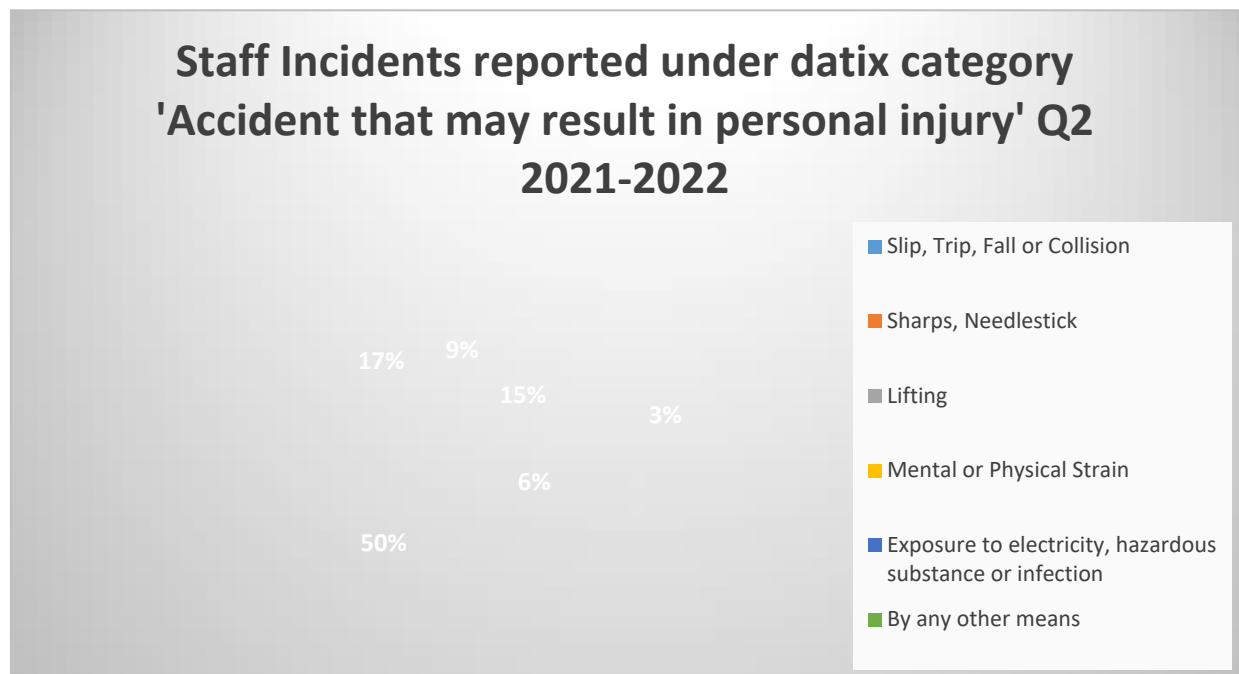
6. Datix incidents (Personal Injury)

A total of 386 staff incidents were reported in Q1 under the datix category 'Accident that may result in personal injury incidents'. These break down into 66 slip, trip, falls and collisions; 109 needle stick and sharps; 15 lifting incidents; 37 injuries caused by mental or physical exhaustion; 60 exposures to electricity, hazardous substances or infection and 99 accidents by any other means. The majority of incidents under this category are mis-categorised. This compares to 772 of staff incidents reported in Q1 under the datix category 'Accident that may result in personal injury incidents' in Q1 of 2020-2021.



A total of 619 staff incidents were reported in Q2 under the datix category 'Accident that may result in personal injury incidents'. These break down into 51 slip, trip, falls and collisions; 87 needle stick and sharps; 19 lifting incidents; 36 injuries caused by mental or physical exhaustion; 296 exposures to electricity, hazardous substances or infection (267 are marked as COVID-19 related) and 130 accidents by any other means. The majority of incidents under this category are incorrectly categorised. This compares to 427 of staff incidents reported under the datix category 'Accident that may result in personal injury incidents' in Q2 of 2020-2021.

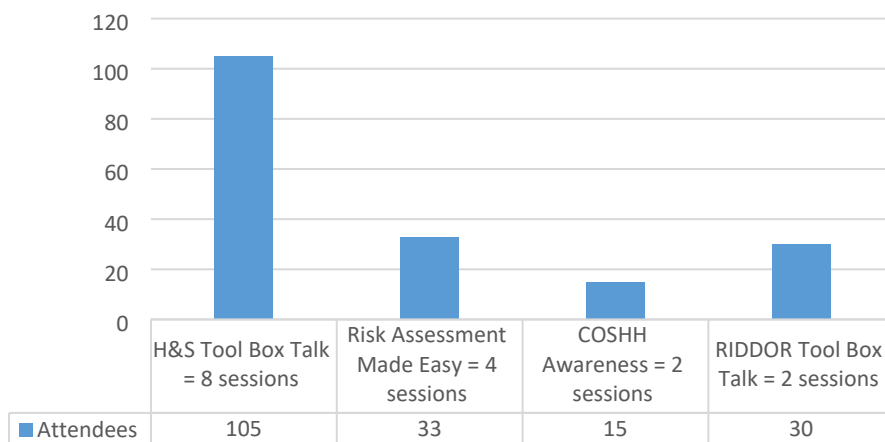
When we look at the total numbers of incidents reported across the two quarters for both years, there is a relatively small change iro 100. Further work is underway to track this reporting in real time to understand whether there are patterns linked to other factors. This will inform the deployment of resources against the key accident areas e.g. needle stick and sharp as well as improving the accuracy of categorisation.



7. Health and Safety Training

The Corporate H&S Team training has recommenced training in COSHH, risk assessment and RIDDOR along with a Manager's H&S Toolbox talk. These courses take place on a rolling four-week program and are delivered via teams. In Q1, 7 training courses took place with 108 attendees. In Q2, these training courses were incorporated into ESR meaning that they can be accessed directly through self-service and completion automatically recorded in the employee record. A further 8 training courses took place with 85 attendees. Feedback continues to be positive and this team KPI continues to be achieved.

Breakdown of H&S Training by Attendance - Q1 & Q2 2021-2022



8. Security

Security/V&A related policies and procedures

Update on progress of the following documents:

Policy	Status
The Management of Violence and Aggression Procedure	Completed and available on Intranet.
Security Procedure	Draft procedure in place, this remains under review during the restructure of security management in BCUHB. Anticipated to go out for the initial consultation in November 2021.
CCTV Policy and Procedure	The final draft of CCTV policy is now ready and will go to the Strategic Occupational Health and Safety Group in November 2021
Lone Working	Completed draft has been circulated to H&S Leads & Union partners for comment. To be presented to the Strategic Occupational Health & Safety Group in November 2021 and the Security Management Group once restarted
Lockdown	BCUHB Statutory Compliance, Governance & Policy Manager has suggested that Lockdown policy become a subordinate "procedure" under the Business Continuity/Emergency Planning Policy. Draft documents to assist in the development of such a procedure have been forwarded to the Head Of Emergency Preparedness, Resilience & Planning.

As each Policy document is approved, a programme of compliance monitoring is agreed, including, but not limited to, spot checks, Health and Safety reviews, Make it Safe Reviews assessing compliance with Policy as a core standard etc. In addition, work is underway to agree a plan for audits through 2022/23.

Incidents (Security & V&A)

Security Incidents reported in Q1 on the Datix system are largely comparable to those over the previous 2 years. Of the 1,414 Security/V&A Datix incidents recorded on Datix, 1,384 were reviewed by the Security Management Service, achieving 97.8% scrutiny of all incidents. These reviews have identified that 338 incidents appear to be self-harm incidents, which are considered “clinical” events. As such all incidents listed as “self-harming behaviour” will be removed from incidents reviewed by the Security Management Service.

The Security Advisors reviewed all 841 datix incidents for the Q2 period, and provided interventions in 509 of those incidents. Contact is made with department managers and where possible the staff member for all incidents in which staff are injured and/or police are involved.

Work is underway to establish an alert system for violent incidents resulting in harm. This will form part of the Health Boards response to the call for improvement from the National Collaborative but is also something that we believe will assist in gathering real time evidence to inform future strategy. In addition, further benchmarking data is being gathered from Health Boards across Wales to assist in understanding those issues that need a bespoke solution in North Wales.

Security/V&A Training

There remains a national issue with access to Module B Violence & Aggression E- learning and the current compliance is 41%. The ESR team have identified a solution which should see the compliance improve once implemented. Compliance with Module A E-learning remains high at 84.2% across BCUHB.

Module C V&A Breakaway training is delivered in the classroom and has now recommenced with training being delivered to higher risk areas. Current recruitment for additional trainers is being undertaken.

Q2 Module C Breakaway Sessions				
Total Booked		Withdrawn	Attended	DNA
Staff numbers	141	8	88	46
		5.67%	62.41%	32.62%

Security Management Provision

Security guards are deployed at:

- Ysbyty Gwynedd, Wrexham Maelor, Ysbyty Glan Clwyd.
- Deeside temporary Hospital Site.
- Vaccination centre Tennis Centre, Caernarfon.
- Vaccination centre Ffriddoedd road, Bangor.
- Sector House, Argyll Road, Llandudno.
- Optic Vaccination centre, St Asaph.
- Catrin Finch Vaccination centre, Wrexham.

Regular reviews take place with Covid 19 logistics group to supply any security advice or personnel in respect to Local Vaccination Centres.

9. Manual Handling

Training

Access to training rooms remained challenging in Q1 and Q2 over the three main sites, having an effect on accessibility for staff especially in the West due to the larger geographical area. Temporary rooms that had been set up in Llandudno General Hospital were no longer available to the training team. Staff sickness and planned updating of training in line with the All Wales Passport and Information Scheme (Passport Scheme) has meant that training offered has been limited with no training available in August 2021. This is, in the main being resolved with additional physical capacity identified and with final locations due to come on line in January 2022.

During Q1, the team were able to provide 37 Foundation classes and 135 Refresher classes, offering a total 1,320 places. The DNA rate has increased this year and courses cancelled, with reasons given as staff shortages and work demands. Foundation saw 24% classes cancelled and 28% DNA attendance, with Refresher seeing 27% cancelled and 47% DNA attendance. Compliance continues to drop and is currently 58%. These figures do not include the Health Science Students or Temporary Staffing requirements on training and these shortfalls will accumulate and potentially leave BCUHB at further risk of untrained staff.

The interactive Microsoft Teams course for Level 1 training was rolled out in Q1. 15 classes were offered with the potential for 300 places; 40% of courses were cancelled as empty and 43% DNA rate for attendance at those that went ahead. The department recommenced the two-day Champion course, 19 classes with 114 places in this quarter, to upskill staff and ensure gold standard manual handling occurs in their workplace, reduce MSK's and Datix, and update peers in compliance in training. This course has seen 37% cancelled as low bookings and 32% DNA for attendance. The courses are now on hold temporarily so that the team can focus on Foundation and Refresher training. During Q2, the team provided 29 Foundation classes and 52 Refresher classes, offering a total 486 places. Due to staff sickness the courses cancelled have increased this quarter and the DNA rate remains 35% with reasons given as staff shortages and work demands. Compliance for patient handling refresher courses continues to drop and is currently 55%. These figures do not include the Health Science Students or Temporary Staffing requirements on training and these shortfalls will accumulate and potentially leave BCUHB at further risk of untrained staff.

The interactive Microsoft Teams course for Level 1 training has continued this quarter. 11 classes were offered with the potential for 200 places; 3 courses were cancelled due to staff sickness and 18 places remained unfilled despite regular advertising through BCUHB communications.

During Q1 the training programme was critically analysed alongside the All Wales Passport and Information Scheme (Passport Scheme). The current training being delivered in BCUHB was compared with other Health Boards in Wales, including the qualifications/ competencies of the training team, times for courses and content. An SBAR was developed to highlight the gaps to the Executive Team. In September 2021 the new courses were trialled in the Central region and this has been rolled out across BCUHB in Q3.

10. Fit testing

Fit Testing Programme team

Following the issuing of an Improvement Notice in August 2020, the Executive Team authorised a number of changes to the fit testing program across BCUHB. These changes included the introduction of a dedicated fit testing program team, fit testing hubs on the DGH sites, the move to quantitative testing via the PortaCount machines, the retraining of all fit testers to ensure competence and the recording of fit tests and training on ESR. The Fit testing Programme Team members were recruited on a secondment basis and a business case has been submitted to the Executive Team for substantive posts.

The Fit Testing Programme currently has a Fit Testing Coordination Team Manager (based in Central), 1 Regional Coordinator (West) and an Information Systems Officer. The Regional Coordinator post for the East went out for advert in Q2.

Achievements for Q1 and Q2 are as follows:

FSM18 single-use respirator trial

Trial of the Full Support FSM18 was completed in Q1, feedback gained and results analysed. We achieved a 95% pass rate for people who had already failed on the other single-use variants, in part due to the smaller size of the FSM18.

An SBAR was submitted for Executive attention outlining the benefits and costs of adopting this respirator. This has now been approved with the team undertaking the management and control of their use.

Respirator Identification Card Trial

Following a further HSE Notification of Contravention, there was a requirement to ensure information and monitoring of correct use of respirators. The trial compiled of a carry card for the end user which would give at-a-glance:

- Identification to the user and auditors on which respirator(s) the user has been successfully fitted with
- Reminder information on factors which can affect the efficacy of the fit, and therefore protection level

An SBAR was submitted to the Executive Team which included scope and costs of implementation. This was approved and the ordering of the printers and cards has been undertaken.

Fit Testing Escalation Protocol

Due to clinical fit testers being drawn back as clinical activity has increased, reduction of number of active Fit Testers caused a deficit in resource for Fit Testing. In recognition of this, the Executive's supported the need for an Escalation Protocol which would allow the team to escalate to HMTs and Area Management Teams when there was a need to scale up fit testing program work. This was written, communicated to Directors and went live on the Intranet on 01/07/2021. This is being supported by HMTs however there remained shortages. Recruitment is going forward for additional fit testers on a temporary / seconded basis to work directly with the team.

Fit Testing Activity

Across BCUHB in Q1 1,377 fit tests were undertaken and in Q2 1,178, fit tests were undertaken

11. Recommendations for Q1 and Q2

- Ensure adequate staffing is available to provide an appropriate Health and Safety, Security, Fit Testing and Manual Handling function to BCUHB
- Develop the objectives for the next 12 months which are aligned to COVID-19 requirements monitoring systems to measure performance including clear KPIs.
- Implement Policies for Security and V&A and review structure and contract
- Ensure appropriate training facilities and trainers are available to ensure MH risk is reduced from the current level

12. Additional information

Lone working

The BCUHB Workforce and Organisational Development team has identified a total of 1,381 community workers who may benefit from use of a device who explored numbers in the following staff groups:

- Community midwives.
- District Nurses.
- Community Health Visitors.
- Community mental health workers.
- Substance Misuse workers.
- Community Physios.
- Community Occupational Therapists.

The Executive Team approved the recommendation to undertake a trial and appraisal of 200 lone worker devices and to adopt a corporate approach to lone working including mandatory training for all managers of staff who work alone.

In addition, the following measures have been approved:

- Lone Worker Procedure document:
- Lone worker risk assessment templates and advice document/checklist;
- Lone worker advice is a feature of the BCUHB Violence & Aggression training programme;
- Bespoke training sessions for lone workers in the community;
- Appointment of Violence & Aggression (Personal Safety) Trainers. 2 trainers have been offered posts within BCUHB and a starting date is provisionally been set for the end of December 2021;
- Those lone worker devices currently in operation within BCUHB fall under the remit and management of the trial with a view to explore usage and functionality;
- provide assurances that lone worker device will not be used to monitor employee's locations for disciplinary procedures;
- ensure that employees have access to BCUHB mobile phones when engaged in Lone working duties;

- employees who are expected to drive vehicles are suitably equipped with First Aid Kits, High Visibility Vests and a Reflective Warning Triangle;
- those lone workers who conduct duties in hours of darkness be equipped with a torch/head torch or similar.

HSE planned inspection

A planned inspection was undertaken by the HSE from the 16th to the 18th of November 2021. This inspection was specific to Manual Handling, Violence and Aggression, COVID-19 safety compliance and a review of the Patient Falls documentation and process following the previous Improvement Notice. There were two inspectors, one based on the Wrexham Maelor site and the second who split their time between YGC (one day) and YG (two days).

The HSE inspector did advise that overall the inspection went very well and they recognised the significant progress made with a positive direction of travel with the Health and Safety Team and the Health Board since their last visit in 2016.

Initial verbal feedback from the inspectors advised that the HSE would issue two Improvement Notices, the first is specific to Porters in YG for failing to undertake suitable and sufficient Manual Handling risk assessments. The second is for failing to complete suitable and sufficient Patient Handling risk assessments across BCUHB. There will be other advisory notes in the feedback to the health board including reviewing and updating policies, a programme to be put in place in regards to ventilation and a review of car parking on the Wrexham Maelor site. A full report on this will be given in the Q3 report once the documented feedback has been received.

Health & Safety Snapshot

Q1: April-July
2021

- 49 Corporate H&S Reviews completed.
- 84 social distancing Visits.
- 7 Training Sessions with 108 attendees.
- 22 H&S Guidance documents created in partnership with other services to support H&S self assessment tool.
- Reviewed/updated 9 H&S procedures & guidance documents.
- Report on RIDDORs weekly to the Exec Bulletin.
- Developed & ratified a Control of Noise Procedure

Health & Safety

- 1446 training places made available.
- Courses offered-People Handling Foundation & Refresher, Inanimate Load & Champions.
- High Rates of staff not attending training places.
- 12 return to work Risk Assessments completed
- 46 Display Screen Equipment Assessments completed

Manual Handling

- Obligatory Responses to Violence in Healthcare gains Welsh Circular Status.
- HS02 Guidance Protecting employees from Violence & Aggression Reviewed/Updated.
- 100% Datix Reviews Completed.
- V&A Risk Assessment templates updated.
- 6 Obligatory Responses to Violence in Healthcare. information session delivered to North Wales police
- Staffing review leads to refocusing of V&A Case Management.

Security/Violence
& Aggression

- FSM18 single-use FFP3 Respirator Trial completed and implementation SBAR written
- Respirator Identification Card Trial completed and implementation SBAR written
- Fit Testing Escalation Protocol developed and communicated to HMTs and Area Management Teams
- East Fit Testing Hub established in Wrexham
- 1377 Fit Tests undertaken

Fit Testing

Management:

- Staffing review leads to refocusing of V&A Case Management.
- 6 Obligatory Responses to Violence in Healthcare. information session delivered to North Wales police
- V&A Risk Assessment templates updated.
- 100% Datix Reviews Completed.
- HS02 Guidance Protecting employees from Violence & Aggression Reviewed/Updated.

- 1377 Fit Tests undertaken
- East Fit Testing Hub established in Wrexham
- Fit Testing Escalation Protocol developed and communicated to HMTs and Area Management Teams
- Respirator Identification Card Trial completed and implementation SBAR written
- FSM18 single-use FFP3 Respirator Trial completed and implementation SBAR written

Health & Safety Snapshot

Q2: July-Sept
2021

- Nitrous Oxide Report for Maternity completed.
- 31 Corporate H&S Reviews completed.
- 73 social distancing visits.
- 8 Training Sessions with 85 attendees.
- 10 Acute sites walkabouts with Trade Union partners.
- 8 Area Corporate H&S reports provided to Area and Acute Directors.
- 4 RCA Scrutiny Reviews for effectiveness and suitability undertaken and lessons learnt/feedback given.
- H&S support for the Reusable Gown Clinical Trial Ysbyty Gwynedd.

Health & Safety

- 706 training places made available.
- Courses offered in People & Inanimate Load Handling.
- 35% Non-Attendance rates for training.
- New training programme created, realigning with All Wales Passport.
- Vacancies for Clinical Trainer & Advisors advertised.
- Provision for external training venues being explored.
- 13 "Back to Work" assessments completed
- 57 Display Screen assessments completed.

Manual Handling

- HS02 Guidance "Protecting Employees from Violence & Aggression" Now ratified & on Intranet.
- 12 Face to Face Breakaway training sessions completed, 141 staff trained.
- V&A E-learning remains available to all staff.
- 100% Datix Reviews Completed.
- Security guards deployed 24/7 to 3x District Hospital Sites.
- Draft policy documents for CCTV use and Loneworking completed.

Security/Violence & Aggression

- fit Testers Information Pack set up and distributed.
- Validation of trained fit testers undertaken to confirm team
- Peer reviews of fit testers now underway.
- Staff survey on Staffs fit testing experience: 99% felt confident on leaving the hub.
- Central fit tests undertaken: 479
- West fit tests undertaken: 474
- East fit tests undertaken: 225

Fit Testing

- Loneworking completed.
- Draft policy documents for CCTV use and Hospital Sites.
- Security guards deployed 24/7 to 3x District
- 100% Datix Reviews Completed.
- V&A E-learning remains available to all staff.

- East fit tests undertaken: 225
- West fit tests undertaken: 474
- Central fit tests undertaken: 479
- Staff survey on Staffs fit testing experience: 99% felt confident on leaving the hub.
- Peer reviews of fit testers now underway.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Patient Experience 11 January 2022						
Cyhoeddus neu Breifat: Public or Private:	Private						
Teitl yr Adroddiad Report Title:	Quality in General Surgery at Ysbyty Glan Clwyd						
Cyfarwyddwr Cyfrifol: Responsible Director:	Dr Nick Lyons						
Awdur yr Adroddiad Report Author:	Dr Nick Lyons						
Craffu blaenorol: Prior Scrutiny:	Updated since noted at Executive Team meeting on 1 December 2021						
Atodiadau Appendices:	None						
Argymhelliad / Recommendation:							
The committee is asked to note the report							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	N	Ar gyfer Trafodaeth For Discussion	Y	Ar gyfer sicrwydd For Assurance	N	Er gwybodaeth For Information	N
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
No							
Sefyllfa / Situation:							
A number of recent issues have led to a thematic review of the current safety and quality of the general surgery services in Ysbyty Glan Clwyd (YGC). This paper summarises those issues and describes the immediate actions and next steps in order to both reduce the immediate risks and inform future actions. This work has been developed in close partnership between the YGC Hospital Management Team and the Executive Directors of Medicine and Nursing and Midwifery / Deputy Chief Executive Officer.							
Cefndir / Background:							
The issues leading to the current review are:							
<ol style="list-style-type: none"> 1. The results of the National Emergency Laparotomy Audit (NELA) for the last 4 years show YGC as an outlier in terms of patients needing non-planned admissions to Intensive Care or requiring a further urgent surgical procedure after an initial surgical procedure in YGC. 2. The results of the 2021 National Bowel Cancer Audit (NBOCAP) suggest a higher than expected mortality in the 2 years after surgery in YGC, compared with other sites in BCUHB and compared with national results, a finding that has been seen in earlier NBOCAP audits. 							

3. 3 deaths occurred in a short period of time in surgical wards associated with unexpected deterioration shortly after a surgical procedure in YGC
4. 2 Never Events in theatres in YGC (although not in general surgery patients)
5. Current recruitment difficulties in surgery in YGC
6. The preliminary results of a review of the colorectal workforce highlighting the current fragility of the surgical rota in YGC, particularly in the colorectal workforce
7. A higher than expected proportion of clinical negligence claims relating to surgical care in YGC

A round table in November 2021, which included the site Medical Director and the Executive Medical Director, considered whether any immediate change in service delivery was required because of the information above and it was decided not, but to revisit this decision after the review of the 3 deaths.

This position was reviewed and supported by a surgeon external to the YGC team and subsequently further supported by the external reviewer after the initial case review.

Opsiynau a ystyriwyd / Options considered

The immediate actions already completed include:

A stronger focus on the locum consultant workforce with some changes in the skill sets to ensure greater resilience to the on-call arrangements.

A review of locum arrangements that has resulted in one locum being given notice and information relating to this doctor has been shared with regulators. There is also a renewed focus on clinical competencies and this has resulted in a further locum not being appointed following an initial review of skills.

Support for the local surgical leadership team, including mentorship from the Royal College of Surgeons. This has commenced.

The attendance of the Hospital Management Team for 2 days in an English Trust that was rated CQC "Outstanding" in November 2021.

A review of the risk registers at site level, with surgical staffing levels added to that risk register

A review of the NBOCAP data showed that some of the "outlier" status related to the quality of historic data presented to the national audit team. The national team are not able to revise the data that will be published but a data validation process has now been introduced.

Initial investigations into the 3 deaths in YGC, which suggest no common themes or immediate changes in practice, are needed. The formal investigations are awaited and are expected in February 2022.

The longer term steps to mitigate more fully any risks are

The analysis of the most recent NELA audit, received in the week commencing 20th November 2021, shows a reduction in “adjusted mortality” and the high-level adjusted mortality is now 5.3% (national average 8.3%). Close monitoring of the NELA audit will continue at local governance meetings and site quality meetings.

The NBOCAP data will be quality assured before submission in future.

Proposals for an enhanced MDT process to ensure better case selection are being developed and will be implemented in Q4 2022/2023.

The triangulation of results from individual audits will be a part of the developing Clinical Effectiveness work to be implemented in 2022/2023

Analysis of CHKS data, including Risk Adjusted Mortality (RAMI) across the surgical pathways in the BCUHB and this will be compared with comparator sites elsewhere in the UK. This work is expected in Q4 2021/2022, although current response to COVID pressures may delay this.

Further actions under development include:

Convening of a quality workshop led by the Hospital Management Team, with support from Clinical Executives, with the surgical team following the receipt of the investigations into recent deaths. This will be held within 4 weeks of receipt of the final investigation reports

Commissioning of external resource and expertise to support and move forward at pace the Human Factors training in BCUHB, with initial focus on YGC and the effective use of the WHO checklist. This will commence, subject to any COVID restriction delays, in Q4 2021/22.

Refocussing of existing resource from Kendall Bluck to review in more detail the general surgery workforce in YGC, building on the initial work in relation to the colorectal team. This work has commenced and will be completed in Q4 2021/22.

A renewed focus on the recruitment of substantive consultant surgical staff, with the use of different recruitment media and the use of more flexible job plan offers to recruit staff (potentially with more opportunities to work with Universities for example)

Goblygiadau Ariannol / Financial Implications

Changes in medical staffing establishment are the most significant risk and those recommendations have yet to be received. Other costs are within current 2021/22 budgets.

Dadansoddiad Risk / Risk Analysis

A review of the current risk register is underway

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

None at present

Asesiad Effaith / Impact Assessment

Not yet completed pending further analysis of any actions



Cyfarfod a dyddiad: Meeting and date:	Quality, Safety & Experience (QSE) Committee						
Cyhoeddus neu Breifat: Public or Private:	Public						
Teitl yr Adroddiad Report Title:	Quality Governance Self-Assessment Action Plan						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Awdur yr Adroddiad Report Author:	Matthew Joyes, Acting Associate Director of Quality Assurance						
Craffu blaenorol: Prior Scrutiny:	Matthew Joyes, Acting Associate Director of Quality Assurance Gill Harris, Executive Director of Nursing and Midwifery/Deputy CEO						
Atodiadau Appendices:	None						
Argymhelliad / Recommendation:							
The Committee is asked to approve closure of the Quality Governance Self-Assessment Action Plan.							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	✓	Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
Sefyllfa / Situation:							
<p>Following submission of the Quality Governance Self-Assessment to Welsh Government on 07 January 2020, an action plan was developed that recorded each action identified in the submission and a lead officer and target date.</p> <p>The Committee has received updates throughout the last 2 years, the latest in November 2021 with a position update. The Committee is now asked to approve closure of the action plan.</p> <p>This work should be considered in the context of the imminent report of Welsh Audit Office Review of Quality Governance, the ongoing Corporate Governance Review, the professional support from the Good Governance Institute and Stronger Together organisational development work which all commenced post this action plan.</p>							
Cefndir / Background:							
Following well publicised events at Cwm Taf Morgannwg University Health Board, the Royal College of Obstetricians & Gynaecologists (RCOG) was commissioned by the Welsh Government to undertake an external review to investigate the care provided by the health board's maternity services. The							

review took place on 15-17 January 2019, and at the request of Welsh Government, the resulting report and its findings/recommendations informed a local benchmarking exercise involving health boards across Wales. Each Health Board was asked to consider its own maternity services in the context of the recommendations of the report and to provide assurances on the safety of those services. The Women's Directorate in the Health Board undertook this benchmarking exercise and submitted the outcome to Welsh Government in May 2019. Some areas for ongoing improvement were identified and have been taken forward as part of the Directorate's learning culture and service development.

In November 2019 Healthcare Inspectorate Wales and the Wales Audit Office issued a report titled 'A review of quality governance arrangements at Cwm Taf Morgannwg University Health Board'. The Minister for Health and Social Services requested that all health boards and NHS trusts in Wales assess themselves against the recommendations of the review and provide plans for future review of their arrangements and/or the necessary action to be undertaken. The self-assessment was required to include a narrative of current arrangements and the current level of assurance as high, medium or low.

The Board held an extraordinary workshop session in December 2019 as part of its process for determining its self-assessment response. The approved version of the response was submitted to Welsh Government on 07 January 2020 and reported to the QSE Committee that month.

The self-assessment response sets out the Health Board's current position across 7 areas:

- Strategic focus on quality, patient safety and risk
- Leadership of quality and patient safety
- Organisational scrutiny of quality and patient safety
- Arrangements for quality and patient safety at directorate level
- Identification and management of risk
- Management of incidents, concerns and complaints
- Organisational culture and learning

Levels of assurance, based on the current position, were allocated, based on the following definitions: 'a self-assessment of 'high' indicates substantial assurance on the effectiveness of the quality governance arrangement in question, with few or no matters requiring attention. 'Medium' indicates reasonable assurance, with some matters requiring management attention. 'Low' indicates limited or no assurance, with more significant matters requiring management attention'.

Asesiad / Assessment & Analysis

The achievement of the actions in the plan have helped strengthen governance arrangements within the Health Board.

In the November 2021 report, the only open actions are included below:

- Engagement, development, approval, and implementation of a new Quality Strategy
- Engagement, development, approval, and implementation of a new Clinical Strategy

- Deploy a single improvement system and establish Clinical Summits to lead on clinical pathway improvements

As these actions are being taken forward as part of new strategy development processes and Stronger Together (work which commenced post this action plan being implemented) the Committee is asked to formally close the Quality Governance Self-Assessment Action Plan.

The outstanding actions will be completed through the separate processes, and the Health Board awaits the Welsh Audit Office Review of Quality Governance which will provide the framework for the next round of quality governance improvement. This external audit report, which follows work done during 2021m will provide a strong basis for the Committee to receive assurance and gaps in assurance to inform its future work.

Goblygiadau Strategol / Strategy Implications – Not applicable.

Opsiynau a ystyriwyd / Options considered - Not applicable.

Goblygiadau Ariannol / Financial Implications – Not applicable.

Dadansoddiad Risk / Risk Analysis – This is contained within the report.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance – This is contained within the report.

Asesiad Effaith / Impact Assessment – Impact assessments are not required for this report.

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety, Experience – 11th January 2022						
Cyhoeddus neu Breifat: Public or Private:	<i>Public</i>						
Teitl yr Adroddiad Report Title:	Internal Audit HASCAS Report						
Cyfarwyddwr Cyfrifol: Responsible Director:	Gill Harris, Deputy CEO / Executive Director of Nursing & Midwifery						
Awdur yr Adroddiad Report Author:	Huw Thomas, Senior Internal Auditor						
Craffu blaenorol: Prior Scrutiny:	<i>Report produced and presented at Audit Committee</i>						
Atodiadau Appendices:	<i>Audit Committee Progress Report</i>						
Argymhelliad / Recommendation:							
<p>That the QSE Committee note the:</p> <ul style="list-style-type: none"> • Internal Audit report (1st September 2021 to 30th November 2021) • Internal Audit briefing paper for the review of closures / progress against the HASCAS & Ockenden reviews (HASCAS Recommendations 14 & 15), October 2021 							
Ticiwch fel bo'n briodol / Please tick as appropriate							
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval		Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance	X	Er gwybodaeth For Information	
Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol Y/N to indicate whether the Equality/SED duty is applicable						N	
n/a							
Sefyllfa / Situation:							
<p>To provide assurance that there is sufficient evidence to support the closing of the recommendations arising from the HASCAS and Ockenden reports.</p> <p>Internal Audit report has previously been presented at Audit Committee as noted in the Internal Audit Progress Report attached at Appendix 1.</p> <p>Actions will be tracked by Internal Audit and for completeness the outstanding recommendations from the HASCAS Internal Audit Briefing paper have been referred to QSE for tracking.</p>							

Cefndir / Background:
<p>The Health Board at its meeting held 11th March 2021 approved the closure of the former HASCAS & Ockenden Improvement Group noting that work for the 35 recommendations continued to be monitored through existing forums within each of the responsible divisions, which subsequently reported into a relevant committee.</p> <p>It was also noted that the Internal Auditors were reviewing evidence for fully implemented recommendations.</p>
Asesiad / Assessment & Analysis
<p>Goblygiadau Strategol / Strategy Implications</p> <p>The Internal Audit Progress Report attached at Appendix 1 confirms the review undertaken to ascertain whether there was adequate evidence provided to support the narrative in the closure of the recommendations mentioned above. The internal audit report confirms reasonable assurance against the output of the HASCAS & Ockenden external reports recommendations progress and reporting.</p> <p>The report also confirms that a review of evidence to support the progress/closure for recommendations 14 & 15 of HASCAS (End of Life planning), was also undertaken as stated in the Improvement Group Monthly Highlight Report and Quality, Safety & Experience Committee and confirmed that both recommendations are considered partially implemented, with the impact of COVID affecting full implementation (see Appendix 2).</p>
<p>Opsiynau a ystyriwyd / Options considered</p> <p><i>n/a</i></p>
<p>Goblygiadau Ariannol / Financial Implications</p> <p><i>n/a</i></p>
<p>Dadansoddiad Risk / Risk Analysis</p> <p><i>n/a</i></p>
<p>Cyfreithiol a Chydymffurfiaeth / Legal and Compliance</p> <p><i>n/a.</i></p>
<p>Asesiad Effaith / Impact Assessment</p> <p><i>n/a</i></p>

Audit Committee

[Title]

1st September 2021 to 30th November
2021

NWSSP Audit and Assurance Services

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Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Betsi Cadwaladr University Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Introduction

1. This progress report provides an update to the Audit Committee in respect of the assurances, key issues, and progress against the Internal Audit (IA) Plan for 2021/22 which have been finalised since the last Committee meeting. Final reports detailing findings, recommendations and agreed actions are issued to the Committee's Independent Members through the Office of the Board Secretary.

Reports Issued

2. Several reviews have been finalised in conjunction with Health Board management. A summary of these reviews is provided below in Table 1.

Table 1 – Summary of assurance reviews issued as final

Title	Assurance Level	High	Medium	Low	Key Messages
HASCAS & Ockenden external reports: Recommendation progress and reporting Review completed July 2021 with Executive approval October 2021	Assurance Not Applicable	-	-	-	We undertook a review to ascertain whether there was adequate evidence provided to support the narrative in the closure of the recommendations mentioned above. A review of evidence to support the progress/closure for recommendations 14 & 15 of HASCAS, as stated in the Improvement Group Monthly Highlight Report and Quality, Safety & Experience Committee, was undertaken. Both recommendations are considered partially implemented, with the impact of COVID affecting full.
Secondary Care Division – Ysbyty Glan Clwyd Review completed November 2021 with Executive approval November 2021	Assurance Not Applicable	3	-	-	We undertook a review of the management arrangements within Ysbyty Glan Clwyd for ensuring effective governance and stewardship, including corporate and financial governance arrangements. At the outset we recognised there have been several changes within the Hospital Management Team over the last year with substantive appointments made within the leadership team recently. Key matters arising from our review were:

Title	Assurance Level	High	Medium	Low	Key Messages
					<ul style="list-style-type: none"> • Lack of effective oversight and monitoring of the implementation of actions to address the Quality Governance Review recommendations. • Lack of effective governance arrangements in place, with majority of reporting to secondary care, bypassing the Hospital Management Team. • There are significant challenges to delivering the savings required for the site.
<p>Upholding Professional Standards in Wales</p> <p>Review completed August 2021 with Executive approval September 2021</p>	Reasonable	-	2	-	<p>We undertook a review to establish Health Board compliance with the <i>Upholding Professional Standards in Wales</i> guidance.</p> <p>Key matters arising at the time included:</p> <ul style="list-style-type: none"> • Designated Board Member (DBM) does not write / present reports to the Board for exclusions over 6 months. • DBM does not receive reports from the case manager. • The Scheme of Reservation and Delegation has not been amended to record UPSW requirements. <p>We identified good practice at the Health Board where:</p> <ul style="list-style-type: none"> • The report to the RATS Committee details all cases and not just those required by UPSW, where a practitioner has been excluded or subject to formal investigation. • Two Designated Board Members have been appointed although we recognise one post will become vacant imminently and will require allocation and training.
<p>Maternity Cross-Border Arrangements</p> <p>Review completed</p>	Reasonable	1	3	-	<p>We undertook a review to determine the robustness of maternity cross-border arrangements.</p> <p>Key matters arising included:</p>

Title	Assurance Level	High	Medium	Low	Key Messages
October 2021 with Executive approval November 2021					<ul style="list-style-type: none"> • Clarification of the legal rights of expectant mothers requesting to birth in England. • The robustness of application review and appeal process. • Data collection, reconciliation, analysis, and verification.
Procurement: Contract Management and Single Tender Waivers Review completed October 2021 with Executive approval November 2021	Reasonable	1	2	-	We undertook a review to evaluate whether the Health Board is complying with Standing Financial Instructions and procedures concerning contract management, and the use of single tender and single quotation actions. Key matters arising include: <ul style="list-style-type: none"> • Whilst levels of monitoring for contracts were evident within the contracts we sampled; we were not able to evidence a formalised performance monitoring process for all the contracts sampled. • The NWSSP Contract database contained the incorrect contract manager details for two of the four contracts sampled. • Reasons for approval of single tender waivers sometimes include stipulations for future requests. We were unable to confirm if these are actioned.
Establishment Control: Leaver Management Review completed November 2021 with Executive approval November 2021	Limited	1	1	-	We undertook a review to establish adequacy of the leaver management process within the Health Board, including actions taken by management and the oversight of the process by Workforce & OD Key matters arising include: <ul style="list-style-type: none"> • Holding operational managers to account for non-compliance with Health Board procedures, particularly in ensuring submission of termination forms in a timely manner.

Title	Assurance Level	High	Medium	Low	Key Messages
					<ul style="list-style-type: none"> The Health Board is data rich and information provided to us as part of this review should be included in workforce related reports to all Divisions and Directorates, drawing attention to their poor leaver management, where it applies.

Work in Progress Summary

3. The following reviews are currently in progress:

Table 2 - Draft Reports issued

Review	Status	Date draft report issued
Temporary Hospitals: Follow up of KPMG recommendations	Awaiting Executive approval – Request sent 10 th November 2021.	29 October 2021.
Follow up of Healthcare Inspectorate Wales (HIW)	Management response not yet due.	25 November 2021

Fieldwork

4. The following reviews are currently in progress:

- Learning Lessons – The report has been drafted and is undergoing internal quality assurance.
- Targeted intervention – Fieldwork is complete and the draft report being prepared.
- Planned Care: Waiting List Management – Fieldwork is nearing completion.
- Decommission of Ysbyty Enfys temporary hospitals – Fieldwork is underway, information to support testing has been provided.
- Integrated Service Boards – Fieldwork is underway, information to support testing has been provided.
- Standards of Business Conduct – Fieldwork is underway, information to support testing has been provided.
- Cluster working / Health and Social Care Localities governance and accountability

- Fieldwork has commenced and information to support testing has been requested.
- Business Continuity Plans – Fieldwork is underway and information to support testing has been provided.
- On-Call arrangements – Fieldwork is underway and information to support testing has been provided.
- Recruitment: Employment of Medical Locum Doctors – Fieldwork has commenced and information to support testing has been provided.
- Value Based Healthcare – Initial meetings have been booked to commence fieldwork.

Follow Up

5. Follow up reviews remain in progress as and when actions are noted as 'Implemented – Final Client Approved' for limited and no assurance internal audit reviews only. The follow-up is based solely upon the evidence and narrative included within TeamCentral which supports final approval by the relevant executive lead.
6. Table 3 details the follow-up review(s) of individual recommendations undertaken in the period and whether they have been implemented (Closed – Verified) or rejected (with supporting narrative).

Table 3: Follow-up status of recommendations reviewed

Review Title	Recommendation Title	Follow-up status
Governance Arrangements – Mental Health and Learning Disabilities	Divisional governance arrangements	Closed - Verified
Salary Overpayments	Overpayments procedure	Closed - Verified
Salary Overpayments	Outstanding debts	Closed - Verified

Contingency/Organisational Support/Advice

7. Internal Audit is supporting the Health Board through providing advice and guidance on areas of control, new systems, and processes, with increased time being used to support attendance and provide input at the three project meetings we are in attendance.
8. During the period, the following review/advice/guidance/support has been provided:
 - Attendance at the Health Board Symphony/National WEDS Project Board.

-
- Meeting with Counter Fraud to discuss areas of concern and planned work.

Delivering the Plan

9. The additional support provided to the Health Board with focused reviews is channelled through contingency.
10. As new risks are identified in year, the Board Secretary and internal audit consider the planned reviews against the emerging high-level risks. Following a risk-based assessment of the current plan with the Board Secretary on the 8th October 2021, discussion with the Executive Director Primary & Community Care and Welsh Government timetable for Health Board submission, the following reviews were recommended to the Executive Team for deferment (to be risk assessed as part of the 2022/23 planning process set to commence in December 2021):
 - Digital Strategy – Executive Director has advised that it would be appropriate to defer to quarter 1 2022/23 to allow the implementation of the plan to become embedded.
 - Unscheduled Care – Direct impact on operational services as the impact of COVID-19 continues.
 - Transformation of services – Direct impact on operational services as the impact of COVID-19 continues.
 - Preparedness for Climate Change/Decarbonisation – Submission timeline set by Welsh Government for NHS Wales organisations is March 2022 and therefore any review would not commence until April 2022 at the earliest.
11. Within the plan for 2021/22 there is a review scheduled around major capital schemes funded by Welsh Government, through which the Health Board includes the cost for audit. We have been advised by our colleagues in the Specialist Services Unit of Audit & Assurance that it is unlikely any review will commence on the planned North Denbighshire scheme this year. Consequently, there is a gap in assurance on major capital and capital schemes in the Health Board.
12. The following tables detail the planned performance indicators (Table 3) captured by Internal Audit in delivering the service and the planned delivery of the core internal audit plan (Table 4) with the assurance provided.
13. Table 3 is reporting a positive status across two indicators, however the management response to draft reports has remained at 50%. This is based on eight reports where management responses have been due and is likely to level out as more draft reports are issued and the revised reporting arrangement becomes established.

Table 3 – Performance Indicators

Indicator	Status	Actual	Target	Red	Amber	Green
Report turnaround: time from fieldwork completion to draft reporting [10 days]	Green	100%	80%	v>20%	10%< v<20 %	v<10 %
Report turnaround: time taken for management response to draft report [20 days per Internal Audit Charter and Service Level Agreement] with agreed extension by the Executive Lead at time of agreeing the audit brief	Red	50%	80%	v>20%	10%< v<20 %	v<10 %
Report turnaround: time from management response to issue of final report [10 days]	Green	100%	80%	v>20%	10%< v<20 %	v<10 %

Table 4 – Core Plan 2021-22


Planned output	Outline timing	Status	Assurance
Risk Management	Q4	Review planned for Q4 – planning meeting to be arranged.	
Governance structure	Q4	Planning meeting booked - 14 th January 2022.	
Targeted Intervention	Q3	Review in progress.	
Transformation of services	Q3/Q4	<i>Requested to Defer.</i>	
Impact Assessments	Q3	Brief being drafted.	
Standards of Business Conduct: Declarations	Q2	Review in progress.	
Integrated Service Boards (ISB)	Q2/Q3	Review in progress.	
Budgetary Control & Financial Reporting, including COVID-19 financial governance	Q4	Brief drafted.	

Planned output	Outline timing	Status	Assurance
Procurement: Contract Management & Single Tender Waivers	Q1	Final report issued.	Reasonable
Value Based Healthcare	Q3	Review in progress.	
Learning Lessons	Q1/Q2	Review in progress.	
HASCAS & Ockenden external reports – Recommendation progress and reporting	Q1/Q4	Final briefing paper issued.	Reasonable
Clinical Audit	Q2/Q3	Brief agreed.	
Planned care – Waiting list management	Q1	Review in progress.	
Network and Information Systems Regulations 2018 (NIS Regulations)	Q4	Brief issued, awaiting Executive approval.	
Digital Strategy	Q3	<i>Requested to Defer.</i>	
Cluster working/Health and Social Care Localities governance and accountability	Q2/Q3	Review in progress.	
Unscheduled Care	Q3	<i>Requested to Defer.</i>	
Business Continuity Plans	Q2/Q3	Review in progress.	
Secondary Care Division – Ysbyty Glan Clwyd	Q2	Final report issued.	Assurance Not Applicable
Maternity Cross-Border Arrangements	Q1/Q2	Final report issued.	Reasonable
Recruitment – Employment of medical locum doctors	Q3	Review in progress.	
Roster management	Q4	Review planned for Q4 – planning meeting to be arranged.	

Planned output	Outline timing	Status	Assurance
Establishment Control – Leaver Management	Q1/Q2	Final report issued.	Limited
Upholding Professional Standards in Wales	Q1	Final report issued.	Reasonable
On-Call arrangements	Q2	Review in progress.	
Statutory Compliance: Asbestos Management	Q1	Final report issued.	Reasonable
Waste Management	Q3	Brief being drafted.	
Preparedness for Climate Change/ Decarbonisation	Q4	<i>Requested to Defer.</i>	
Capital Funded Systems	Q4	Brief being drafted.	
Integrated Audit and Assurance Plans	TBC	Please refer to paragraph 11 above.	
Carry over: Temporary Hospitals – Follow-up of KPMG recommendations	Q1/Q4	Draft report issued.	
Carry over: Follow up of previous Healthcare Inspectorate Wales reports	Q1	Draft report issued.	
Contingency: Security Invoice Review	Q1	Final report issued.	Assurance Not Applicable
Contingency: Decommission of Ysbyty Enfyys temporary hospitals	Q3	Review in progress.	

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	<p>Substantial assurance</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.</p>
	<p>Reasonable assurance</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.</p>
	<p>Limited assurance</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved.</p>
	<p>No assurance</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.</p>
	<p>Assurance not applicable</p>	<p>Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.</p>

Briefing Paper

Review of closure/progress against the
HASCAS and Ockenden reviews

NWSSP Audit and Assurance Services
October 2021



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Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board



To: Deputy CEO/Executive Director Nursing and Midwifery
Senior Associate Medical Director

For Information: Macmillan Head of Nursing for Specialist Palliative Care
Risk and Governance Lead

From: Senior Internal Auditor
Head of Internal Audit

Date: 26th October 2021

Regarding: **Briefing Note:**
Review of closure/progress against the HASCAS and Ockenden reviews
(This briefing paper covers recommendations 14 and 15 of HASCAS)



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report (briefing paper) has been prepared for internal use only. Audit & Assurance Services reports are prepared, in accordance with the Service Strategy and Terms of Reference, approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Health Board and no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

To provide assurance to the Board that there is sufficient evidence to support the closing of the HASCAS/Ockenden reports recommendations.

Overview

We have been presented with and reviewed the evidence for the closure of each specific HASCAS / Ockenden recommendation highlighted in the Assurance objective. This briefing paper indicates whether, based on the evidence, recommendations were Implemented or Partially implemented. We have provided a conclusion for each, highlighting, where necessary, what is required or where evidence did not meet the criteria.

Report Classification

Reasonable



Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved.

Trend
N/A

Assurance summary

Assurance objectives

Assurance

1	R14 (HASCAS) Care Advance Directives	Partial
2	R15 (HASCAS) Evidence Based Practice	Partial

1. Introduction & Background

The Ockenden Governance Review (undertaken in 2014) was commissioned formally in conjunction with the HASCAS Consultancy Limited Investigation. The two pieces of work were undertaken independently of each other at the request of the Health Board, and based on the findings and conclusions, provided guidance to the Board on reform through a number of recommendations.

We undertook a review to ascertain whether there was adequate evidence provided to support the narrative in the closure of the recommendations mentioned above.

A review of evidence to support the progress/closure for recommendations 14 and 15 of HASCAS, as stated in the in the Improvement Group Monthly Highlight Report and Quality, Safety & Experience Committee, was undertaken.

2. Scope and Objectives

The overall objective of this review was to provide assurance on whether there was evidence available to support the reported progress in both the HASCAS and Ockenden Improvement Group's Monthly Highlight Report (July 2020) and the Quality and Safety Executive Committee (November 2019).

3. Findings

We have provided a conclusion for each individual recommendation based on evidence provided for each of the HASCAS/Ockenden recommendations covered by this paper, these are detailed in the tables below.

The following findings and conclusions are based upon discussions and evidence provided by the Health Board for each element of the recommendations.

We were provided with evidence to support an extract from the HASCAS & Ockenden Improvement Group Monthly Highlight Report held in July 2020 that related to HASCAS Recommendations 14 and 15 and the providing of assurance for end-of-life planning.

The Headlines & achievements presented were as follows:

1. During the Covid-19 period the OPMH wards have worked in partnership with Palliative and End of Life team members to ensure all had high quality care to the end. There has been mortality reviews with specialists from outside MHLA to quality assure this (sic)

We were provided with a range of anonymised mortality reviews undertaken by specialists as noted.

2. Requested these recommendations are now part of the work of the Strategic Delivery Group for Palliative and End of Life Care (PEoLC) – this has been agreed (sic)

We were provided with the the Terms of Reference (TOR), Agenda and Minutes for the PEoLC Strategic Delivery Group (September 2020 to date) as well as the Strategic Structure for Palliative and End of Life Care to evidence this is being undertaken.

3. Report from National Audit for Care at End of Life has been received and is being considered within the services. This provides a baseline for on-going care improvements (sic)

We were provided with the report for the National Audit for Care at End of Life in Hospitals (NACEL) and evidence of review and discussion at the Strategic Delivery Group for PEoLC in July 2020. We were also provided with the Action Plan that was developed to address areas approved in the September 2020 meeting.

A review of the NACEL Action Plan was undertaken by the Clinical Audit Team on 18th March 2021 and current progress at that time was amber status, this was due to delays caused by the COVID-19 pandemic.

We requested evidence to support the HASCAS & Ockenden Recommendations update report that was provided to the Quality, Safety & Experience Committee in November 2019, the findings of which are as follows:

R14 (HASCAS) Care Advance Directives

BCUHB will conduct an audit to establish how many patients and their families have advance directive documentation within their clinical records together with care plans in relation to choice and preference about end of life care.

1. What monitoring is currently being done and is it evidenced?	The monitoring process for the items stated is encompassed in the Health Boards Stage One Mortality Reviews currently collected across all three hospital sites.
2. Copy of the report for the audit that has been undertaken and evidence of follow-up of the recommendations?	There was evidence of a Clinical Audit provided for the HASCAS Case note Review. Three action points from the review were to be taken up by the newly formed Strategic Delivery Group for Palliative & End of Life Care (EoLC), with support where necessary through Operational Delivery and Academic Sub-Groups to ensure ongoing review and completion of project action plan.
3. Evidence of the new/updated documentation.	New/updated documents were presented and accepted as part of the HASCAS Case note review. However, there were delays the rollout of the amended audit pro-forma and follow up case review due to the COVID-19 response.
4. What were the baseline audit actions identified and how were they taken forward?	<p>It was established that three actions were required from the audit, these were:</p> <ol style="list-style-type: none"> 1. Audit Team to meet and agree an amended audit pro-forma in the light of the outcomes of this base-line case-note review. 2. A Follow-up case-note review to be conducted and completed by June 2020. 3. A business case for multidisciplinary team provision of end of life training and education to be developed. <p>As at the 31st of March 2021 point 1 and 2 were delayed due to COVID-19. With regards to action point 3, MDT training and education sessions were provided. Local EoLC training / support has been provided with discussions taking place to agree formal ongoing training and support.</p>

	<p>The Specialist Palliative Care Team (SPCT) now attend recent older people's mental health (OPMH) mortality reviews and will continue to do so.</p> <p>All three action points now sit with the newly formed Strategic Delivery Group for Palliative & EoLC, supported (where necessary) by Operational Delivery and Academic Sub-Groups.</p>
<p><u>Conclusion</u></p> <p>The monitoring process is encompassed in the Health Board's Stage One Mortality Reviews along with evidence of a Clinical Audit of HASCAS Case note review. Action points from the review had been taken up by the newly formed Strategic Delivery Group for Palliative & End of Life Care (EoLC), with support where necessary through Operational Delivery and Academic Sub-Groups.</p> <p>The newly updated documents that were accepted as part of the HASCAS Case note review should be rolled out at as soon as practicable. These were delayed due to the COVID-19 response.</p> <p>In addition, a follow-up case-note review that was due to be conducted and completed by June 2020 was delayed due to the COVID-19 response, this also needs to be undertaken.</p> <p>MDT training and education sessions were provided. With local EoLC training / support being provided with discussions taking place to agree formal ongoing training and support.</p> <p>The Strategic Delivery Group for Palliative & EoLC need to monitor attendance to the Older People's Mental Health (OPMH) mortality reviews.</p>	<p>Partial</p>

R15 (HASCAS) Evidence Based Practice

Improve end of life environment on OPMH wards and associated guidance training.

<p>1. Evidence to support that the End of Life (EoL) / OPMH pathway has been developed alongside a standard operating procedure (SOP), an MDT / relatives joint risk assessment and a dedicated training module. The draft SOP</p>	<p>The SOP for EoLC was agreed and implemented in OPMH Wards.</p> <p>Meetings with OPMH staff have taken place as part of ongoing support, review, and service developments;</p>
--	--






<p>was presented to Stakeholder Group in January 2019 for their input and minor amendments made from stakeholder feedback. Further changes were made following discussion at the HASCAS EoLC Task & Finish Group which included valuable comments from two members of the stakeholder group who are also members of the Task & Finish Group. The SOP includes real time audit of the process. The low number of deaths on an OPMH ward makes this realistic. The SOP identifies when DATIX is to be used.</p>	<p>work is ongoing with reviewing and developing the SOP.</p> <p>Meetings are currently on hold and will resume once the clinical pressures of COVID-19 allow.</p>
<p>2. Confirmation that relative rooms on each OPMH 'organic' ward are operational.</p>	<p>We have been informed that a relatives' room has been established and operational for all OPMH Wards.</p>
<p>3. Statistics on the Training program: How many staff have undergone training, feedback etc.</p>	<p>We were provided with anonymised attendance list for the PEOLC training day program, with a total of 66 multidisciplinary OPMH staff having attended.</p> <p>Evaluations of training provided positive feedback and comments on how they can be improved.</p> <p>Further opportunities for teaching have taken place during mortality reviews and Specialist Palliative Care Teams continue to support OPMH wards on case by case basis. Plans are to resume face to face teaching once COVID-19 restrictions are eased.</p>
<p>4. Evidence of the Stakeholder Group feedback.</p>	<p>We were informed that HASCAS EoLC Task & Finish Group was established with stakeholder representation early 2019. Meetings ran in 2019. Further meetings have not taken place in 2020 due to the COVID 19 pandemic.</p> <p>Stakeholder visits:</p> <ul style="list-style-type: none"> - 15th July 2019 with Consultant Nurse Dementia and Head of Nursing Specialist Palliative Care to Bryn Hesketh, Colwyn Bay

	<p>Hospital and Cemlyn ward, Cefni Hospital (A feedback summary was produced and shared).</p> <ul style="list-style-type: none"> - Summer 2019 with Consultant Nurse Dementia to Heddfan Unit, Wrexham. - 24th October 2019 to view art work in Bryn Hesketh.
<p><u>Conclusion</u></p> <p>We have been informed that a relatives' room has been established and operational for all OPMH Wards (<i>due to COVID-19 restriction we have not been able to corroborate this</i>).</p> <p>PEoLC training was provided with a total of sixty-six [<i>we do not have the total number of staff this was available to</i>] multidisciplinary OPMH staff having attended. Evaluations were received which included scope to improve if necessary.</p> <p>A HASCAS EoLC Task & Finish Group has been established with stakeholder representation. Meetings ran in 2019, however this was halted due to COVID-19 pressures. These need to be resumed once pressures ease.</p> <p>There was evidence of Stakeholder visits, these need to be resumed after easing of COVID-19 restrictions.</p>	<p>Partial</p>

Appendix A: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
	Reasonable assurance	Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.
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	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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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 (on behalf of Gill Harris)
Date of meeting	09 November 2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	11 January 2022
Presented by	Gill Harris, Executive Director of Nursing and Midwifery

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

- Infection Prevention and Control Team have staffing shortfalls which are likely to lead to prioritisation.
- Concern raised regarding IPC advice not available Out of Hours (microbiology supporting but timely decisions attributing to delay in patient flow decisions).
- Staff pressures across the HB noted
- Targeted Safeguarding Training for Emergency Department Medical Staff as the current compliance is considerably below 85%.
- There is a 44% increase in the number of DoLS applications. WG temporary funding has been received up until March 2022 to support the implementation of MCA training and support an improved position against the DoLS data.
- An Internal Audit Review of BCUHB's management and governance arrangements of cross - border commissioned maternity services identified a need to strengthen PSQG to QSE risk escalation. The Final Internal Audit Report – Maternity Cross-Border Arrangements has been shared with Audit Committee Members via the Board Secretary and the Statutory, Governance & Policy Manager for action plan tracking

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

- **Personal Protective Equipment (PPE) Group:** New PPE products - developed a draft key document with clear principles to follow. Looking at expanding Fit Testing to Independent GP's.

- **Infection Prevention and control:** Review of the size of the IPC team, significantly small in relation to the size of the HB
- **Safer Medications Group:** Successful implementation in Wrexham of the new Pharmacy system being rolled out across the HB
- **Quality System Management:** distributed 60 iPads across the hospital sites, learned from barriers and improved the process now easier to use, also providing more support
- **Safeguarding Governance and Performance:** With support from Workforce have now separated level 2 and level 3 on ESR, compliance will look different. Analysis within key areas completed MH&LD and Womens. Targeting key areas showing low compliance. Linking with Bangor University around Safeguarding training with students
- **All divisions provided a report to the group:**
 - **Secondary Care:** 7 Harm review panels held 146 harms reviews presented to the panel, of which the panel concluded no harm for 145 cases, and the remaining 1 case referred for further review. Urology Cancer surgery capacity – place on the risk register
 - **West Area:** Dermatology – no consultant to cover the service in West until 10th November 2021. Virtual support from East and Central provided.
 - **Central Area:** Care Homes concerns highlighted and being managed. Primary Care 2 x staff on long-term sick leave. Interim person now in place to respond to complainants in a timely manner.
 - **East Area:** DN called to a patient with no DNAR in place required to perform CPR, reviewing process to make more robust and ensure paperwork is in place.
 - **Womens:** Continued concerns regarding CoCH ongoing, highlighted to CEO. Draft letter to CCG to ascertain if have similar concerns
 - **Mental Health:** Ligature work – Learning event on 22nd November working with Estates on Buildings/rooms. Received a lot of support from Estates Team. Unexpected Death in Ty Llewellyn – subject to a workforce investigation
- **COVID Health Acquired Infection review:** Full Investigation Tool kit now available which identifies whether to investigate further. Driven Nationally working towards that Framework, taking a proposal with the 3 options to Executives.
- **Rapid Learning Panel review:** The report outlines key learning and actions for Incidents that have undergone a rapid learning panel April 2021 – to date. Further discussions taking place around identification of themes, areas of concern and planned work for the future
- **Patient Safety Report:** Developing a Training programme to support services
- **Resuscitation Team** Temporary training accommodation has been secured on an interim basis.
- **Patient Safety with IV Infusion Devices – Managing ‘Drug Library’ Safety Systems SBAR paper:** Proposal for funding approved at PSQ is being submitted to Executives

- **3 procedural documents** were submitted for approval – 1 approved :
 - Policy for the Diagnosis and Treatment of Shoulder Conditions Using Ultrasound within the Clinical Musculoskeletal and Treatment Service - **Approved**

3. Achievement – include any significant achievements and outcomes

MH&LD: Winners of the Nursing Times award – 2 teams in BCU working as one



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Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting or Division/Area reporting in	Strategic Occupational Health & Safety Group
Chair of meeting or lead for report	Sue Green - Executive Director Workforce and Organisational Development Peter Bohan – Director of Occupational Health Safety and Security Sue Morgan – Head of Health & Safety
Date of meeting; only if a Sub-group reporting, otherwise 'Not Applicable' (N/A)	2 nd November 2021
Version number	1.0
List Appendices, if applicable	
Reporting To	
Name of meeting	Quality, Safety & Experience Committee (QSE)
Date of meeting	11 January 2022
Presented by	Sue Green – Executive Director of Workforce and Organisational Development

1. Alert

Reporting of injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

With effective COVID-19 management in clinical and non-clinical settings, together with a high uptake of the COVID-19 vaccine by staff, a marked decrease was seen in Q1 in the number of occupational disease reports that were made to the HSE under RIDDOR. This was further evidenced in Q2 with only 3 occupational disease reports being made to the HSE under RIDDOR, for a small staff cluster in Central. Despite two further COVID-19 Outbreaks being declared, in both West and Central, no work-related transmission of COVID-19 to staff has been identified.

A total of 20 RIDDOR reports were made to the HSE in Q2. These break down into:

- 16 incidents involving staff: 2 Needle-stick injuries reported as Dangerous Occurrences, 6 violence and aggression incidents, 3 musculoskeletal injuries, 2 slip, trip and fall incidents and 3 occupational acquired COVID-19.
- 4 patient related falls with Specified Injury

HSE Update

Prior to the COVID-19 pandemic the HSE announced their planned 'Inspections of Violence and Aggression and Musculoskeletal Disorders in Healthcare' programme. This is a national programme planned to examine management arrangements for violence and aggression (V&A) and musculoskeletal disorders (MSD's) at care providers in the public sector. Evidence available to the HSE indicates that assaults on staff and MSD's continue to be prevalent in this sector.

The HSE had notified BCUHB that a planned inspection would take place on the 16th – 18th of November 2021 and will consist of two HSE inspectors. The inspectors will be separately based on the Ysbyty Gwynedd (YG) and Wrexham Maelor Hospital (WMH) site for the three days. The inspector on the WMH site is an Occupational Health specialist inspector and in addition to looking at MSK's and V&A she will be reviewing the COVID arrangements for the site.

Estates risk register

Asbestos Management, Fire Safety and Water Safety remain on the Corporate Risk Register with a current score of 16.

Manual Handling Training

Although work has commenced on locating external training rooms delays with the contracts has meant that the team are still finding it difficult to find training venues. This has been partly mitigated by the use of a meeting room on the Bryn y Neuadd site which has been agreed for eight weeks. The recruitment for six additional Manual Handling trainers has not been successful with only two suitable applicants and the posts will go out for advertising.

2. Assurance

Estates Triple A report

A report was received from the Director of Estates and Facilities who gave an update on the the Board Assurance framework and risk register along with updates from the Safety meetings established in Estates and Facilities.

Divisional Triple A Reports

This was a requirement for reports to be submitted from Hospital Management Teams (HMTs), Area Directors and MHL D. Reports received from Ysbyty Gwynedd and MHL D. All other areas will be contacted to ask for reports at next meeting.

Occupational Health Report

An update was given on the Health Surveillance 12 month programme. Information for the 'nominal role', which is a record of staff who require health surveillance, is being completed and will be reviewed to understand organisational exposures and people at risk.

Health and Safety Reviews

In Q2 a further 31 H&S reviews were undertaken, this was slightly under the agreed KPI, however the social distancing and staying safe program took priority with the changes to Alert Level Zero on the 7th of August 2021 and 73 visits were undertaken.

Health and Safety Training

Training has recommenced for COSHH, risk assessment and RIDDOR along with a Manager's H&S Toolbox talk. These courses take place on a rolling four week program and are delivered via teams. In Q2, eight training courses took place with 85 attendees.

Security / Violence and Aggression incidents

There were 841 incidents in Q2 which were all reviewed by the health and safety (security) team with 509 having interventions provided.

Fit Testing

1,178 fit tests were carried out in Q2 for FFP3 respirators

3. Achievements

- A full-time Strategic Lead has been appointed to support Clinical Psychologists in East who will join the Workforce Wellbeing Group from January 2022
- Emotional Resilience Training Webinars have been arranged for December and February
- Module C (Breakaway) V&A classroom based training has recommenced and training is being delivered to higher risk areas. In Q2, 141 places were offered and 88 staff attended.
- The new Manual Handling training courses have been trialled in Q2 and rolled out in October 2021. This training aligns back to the passport and will be developed with role specific training packages



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	Mandy Jones, Acting Deputy Executive Director of Nursing (on behalf of Gill Harris)
Date of meeting	03.11.2021
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	11 January 2022
Presented by	Gill Harris, Executive Director of Nursing and Midwifery

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

- **Triple A reports from Divisions:**

- Work is underway to recruit temporary additional complaint IO capacity they will be supporting services with the most need.
- Patient flow

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

- **Patient Story:** Vascular services -This story captures the process from initial screening to diagnosis and the delivery of aftercare. Positive reflection on the care provided by the ward staff and Clinicians.
- **Bereavement Quality sub Group:** Developed proposal for Swan Bereavement model. Further discussions around identifying funding streams prior to submitting to Executives
- **Patient Communication and Readers Panels Sub-group:** Key priority of the service is to ensure all HB leaflets have been through the correct process, to provide high quality accessible information
- **CANIAD:** Patients feedback is positive and they feel they are listened to and treated with dignity and respect in partnership with the HB and also around decisions with their care.

- **Community Health Council:** Report submitted requires assurance from HB that the issues identified have been actioned around prepared food and allergens.
- **Healthcare Inspectorate Wales:** On site inspections identified some issues being addressed, in terms of patient experience focus some positives highlighted the staff interacting and treating patients with dignity and respect, patients felt safe and could speak to members of staff if needed to.
- **Ombudsman Complaints Lessons Learned Report:** This report was shared for learning and is related to a patient's poor experience. Clinicians were mis-directed because they did not accept the patients statement that she was not self medicating.
- **NHS Delivery Framework:** submitted to WG, provides evidence on how BCUHB is responding to service users experience feedback to help improve and redesign its services.

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

- Opening of new Dementia and Adult MH Centre Unit at Bryn Beryl, project funded by WG

Cyfarfod a dyddiad: Meeting and date:	Quality, Safety and Experience Committee					
Cyhoeddus neu Breifat: Public or Private:	Public					
Teitl yr Adroddiad Report Title:	Nurse Staffing Levels Policy – amendments to approved policy					
Cyfarwyddwr Cyfrifol: Responsible Director:	Executive Director of Nursing and Midwifery					
Awdur yr Adroddiad Report Author:	Anne-Marie Rowlands, Associate Director Professional Regulation and Education					
Craffu blaenorol: Prior Scrutiny:	The amendments to the Nurse Staffing Levels policy and appendices have been approved at Clinical Policies and Procedures Group and Patient Safety and Quality Group					
Atodiadau Appendices:	<ol style="list-style-type: none"> 1. Nurse Staffing Levels Policy amendments to encompass the extension of the Act to Paediatrics 2. Additional appendices for inclusion as detailed below <ul style="list-style-type: none"> • Appendix four: Movement of Staff • Appendix five: May Reports: <ol style="list-style-type: none"> (i) Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (ii) Appendix: Template for presenting Nurse Staffing Levels to the Board • Appendix six: November Reports: <ol style="list-style-type: none"> (i) Annual Presentation of Nurse Staffing Levels to the Board (ii) Appendix: Summary of Nurse Staffing Levels for wards where Section 25B applies • Appendix seven: Health Care Monitoring System (HCMS) All Wales HCMS User Guide • Appendix eight: Nurse Staffing Levels Deployment Escalation Meeting • Appendix nine: All Wales Paediatric Calculation Template 					
Argymhelliad / Recommendation:						
The Committee is asked to approve the additional appendices and amendments within the Nurse Staffing Levels Policy.						
Please tick one as appropriate (note the Chair of the meeting will review and may determine the document should be viewed under a different category)						
Ar gyfer penderfyniad /cymeradwyaeth For Decision/ Approval	√	Ar gyfer Trafodaeth For Discussion		Ar gyfer sicrwydd For Assurance		Er gwybodaeth For Information
Sefyllfa / Situation:						

The BCUHB Nurse Staffing Levels Policy (2020) is the operational framework, that supports the calculation and maintenance of nursing staffing levels; outlines the roles and responsibilities of key professionals; and identifies the actions that are to be taken to review, record, report and escalate where nurse staffing levels are not maintained.

Cefndir / Background:

The Nurse Staffing Levels (Wales) Act 2016 became law in Wales in March 2016, initially applicable to adult acute medical and surgical inpatient wards. The Act requires health service bodies to have regard for the provision of appropriate nurse staffing levels, and to ensure that they are providing sufficient nurses to allow nurses time to care for patients sensitively. Under the Act, this duty extends to anywhere NHS Wales provides or, commission a third party to provide nurses. From October 2021, the Act was extended to include Paediatric wards.

Asesiad / Assessment & Analysis

Strategy Implications

Health Board Well Being Objectives

- To improve physical, emotional and mental health and well-being for all;
- To target our resources to those with the greatest needs and reduce inequalities;
- To improve the safety and quality of all services;
- To respect people and their dignity;
- To listen to people and learn from their experiences.

Wellbeing of Future Generations Act

- Balancing short term need with long term planning for the future;
- Involving those with an interest and seeking their views;
- Working together with other partners to deliver objectives;
- Putting resources into preventing problems occurring or getting worse;
- Considering impact on all well-being goals together and on other bodies

Financial Implications

There are no funding implications anticipated with the policy amendments.

Risk Analysis

There are no risks anticipated with the policy amendments

Legal and Compliance

The policy has been developed to ensure compliance with the legislation

Impact Assessment

An EqIA has been completed and not identified adverse impact. The policy will have a positive impact as the provision of appropriate staffing will help ensure quality of care across settings, meeting each person's needs. It will also promote a safe working environment for staff and ensure staffing decisions take account of contextual factors. The policy is intended to apply equally to those affected by its provisions, however acknowledges that everyone is different.

Nurse Staffing Levels Policy

Author & Title	Gaynor Hales, Project Lead – Nurse Staffing Act (original author) / Anne-Marie Rowlands, Associate Director Professional Regulation and Education (policy review)				
Responsible Dept. / Director:	Gill Harris, Executive Director of Nursing and Midwifery				
Approved By:	Quality, Safety and Experience Committee				
Date Approved:	13 th December 2021				
Date Activated (live):	2 nd April 2020				
Documents To Be Read Alongside This Document:	<p>Nurse Staffing Levels Wales Act (2016) Statutory guidance Welsh Government; <u>Nurse Staffing Levels: Statutory guidance for Health Boards and NHS Trusts GOV.WALES</u></p> <p>Nurse Staffing Levels (Wales) Act 2016; <u>Nurse Staffing Levels (Wales) Act 2016 (legislation.gov.uk)</u></p> <p>All Wales Nurse Staffing Levels – Key Documents <u>Documents - Nurse Staffing Programme - HEIW (nhs.wales)</u></p> <p>OP01 BCUHB Protocol for the Management of Emergency Pressures and Escalation (2015); <u>http://howis.wales.nhs.uk/sitesplus/861/document/361746</u></p> <p>GC04 BCUHB Operational Scheme of Delegation; <u>http://howis.wales.nhs.uk/sitesplus/861/document/417366</u></p> <p>Paediatrics Escalation Policy - <u>http://howis.wales.nhs.uk/sitesplus/861/opendoc/480540</u></p>				
Date Of Next Review:	November 2024				
Date EQIA Completed:	Updated 19th October 2021				
First Operational:	22 nd April 2020				
Previously Reviewed:	Oct 2021				
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.

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1. INTRODUCTION

Nursing and healthcare staff play a critical role in delivering safe, high quality care to patients and service users with patients at the heart of all that the Health Board do. There is strong evidence that having the right number of staff delivering care in the right place impacts positively on both clinical outcomes and patient experience (Francis 2013, Keogh 2013, and Berwick 2013). Addressing these issues ensures the Health Board prioritise the safety and experience of patients and staff. Clearly safe staffing is not just about staffing ratios, but ensuring that we have the right staff, with the right skills, in the right place at the right time.

The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016, requiring organisations to calculate and monitor the number of nurses required to sensitively care for patients. The Act enables a phased implementation and came into effect for Adult Acute Medical and Surgical Wards in April 2018. The second duty of the Act will apply to Inpatient Paediatric Wards from October 2021.

The Nurse Staffing Levels (Wales) 2016 Operational Guidance has been developed to provide Health Boards with advice on using the Welsh Levels of Care, participating in the biannual audits, analysing results and undertaking triangulation to calculate and report nurse staffing levels. All relevant guidance for the Nurse Staffing Levels Wales programme can be located on the following link: [Documents - Nurse staffing programme - HEIW \(nhs.wales\)](#).

The National (UK) understanding of Professional Nurse Staffing Standards is also made explicit within the NICE publication 'Safe staffing for nursing in adult inpatient wards in acute hospitals' (2014), which can be accessed on the following link: [Overview | Safe staffing for nursing in adult inpatient wards in acute hospitals | Guidance | NICE](#).

2. POLICY STATEMENT

The purpose of this policy is to provide information and standards, which will underpin:

- The Health Board's overarching responsibility to provide sufficient nurses to allow time to care for patients sensitively;
- The calculation of the nurse staffing levels;
- The "reasonable steps" to be taken to maintain nurse staffing levels;
- The escalation and reporting process;
- The requirements to undertake the biannual review of nurse staffing levels.

It is intended that this policy works in conjunction with existing policies and other written control documents issued by the Health Board.

3. SCOPE

The policy is Health Board wide and relevant to those involved in the calculating and maintaining of nurse staffing levels including nursing, workforce, finance and corporate teams.

The policy currently covers all adult acute inpatient medical and surgical wards within Secondary Care as defined by the Act and all inpatient Paediatric Wards that fall under section 25B (see definition appendix one).

Section 25B (3) gives Welsh Ministers the power to make regulations to extend the duty to calculate nurse staffing levels to other settings. The policy would therefore be reviewed when this duty is extended.

4. AIMS AND OBJECTIVES

The aims of this policy are:

- To support the calculation and maintenance of the nurse staffing level;
- To outline the reasonable steps to be undertaken to maintain planned nurse staffing levels;
- To support patients care needs with processes which ensure maximum value from available nurse staffing;
- To provide guidance to nursing staff and managers to safely manage risk to patient safety and staff well-being when not able to maintain the planned nurse staffing level and ensure that this is reported, monitored and appropriate actions are taken to mitigate the risks by taking reasonable steps;
- To provide the mechanism through which open and transparent information on the nurse staffing level on each adult and paediatric inpatient ward within the Health Board can be shared.

The objectives of this policy are to:

- Provide clear and agreed principles for the calculation of the nurse staffing levels;
- Support the maintenance of the nurse staffing level for all adult and paediatric inpatient wards;
- Clarify the roles and responsibilities of all parties involved in the process;
- Provide a clear escalation and reporting process for when the planned nurse staffing level is not maintained.

5. ROLES AND RESPONSIBILITIES

The responsibility for meeting the requirements of the Act applies to staff at all levels, from the ward to the Board, with the Board and Chief Executive being ultimately responsible for ensuring the Health Board's compliance with the Act.

Board

When exercising their responsibilities the Board must consider, and have due regard to, the duty on them under section 25A of the Act to have sufficient nurses to allow the nurses time to care for patients sensitively wherever nursing services are provided.

In addition, the Executive Directors of Nursing, Workforce, Organisational Development and Finance are required under sections 25B and 25C of the Act to provide evidence and professional opinion to the Board to assist with its decision making in relation to calculating and maintaining the nurse staffing level in adult and paediatric in-patient wards.

Roles and responsibilities are detailed below:

Executive Director of Nursing and Midwifery	<p>The designated person who is authorised within the governance framework to calculate the nurse staffing level for the adult and paediatric inpatient wards on behalf of the Chief Executive;</p> <p>Establishes the timetable for the annual cycle, supported by appropriate professional nursing, finance, operational and workforce personnel to facilitate the biannual calculation of the nurse staffing level;</p> <p>Calculates the number of Registered Nurses and those undertaking nursing duties (under the supervision of, or delegated to) by a Registered Nurse appropriate to provide person centred care that meets all reasonable requirements;</p> <p>Undertakes and records the rationale for the calculation every six months as a minimum, or more frequently if there is a change in use / service which is likely to alter nurse staffing level, or if they deem necessary;</p> <p>Formally presents the nurse staffing level for each ward to their Board on an annual basis, provides a written update following the bi-annual recalculation and at any other time recalculation is deemed necessary.</p>
Director of Workforce and Organisational Development	<p>Ensures an effective system of workforce planning, based on the Welsh Planning System, is in place in order to deliver a continuous supply of the required numbers of staff;</p> <p>There are systems in place to ensure active and timely staff recruitment (at both a local, regional, national and international level);</p> <p>There are effective staff well-being and retention strategies in place that take account of the NHS Wales Staff Survey;</p> <p>There are operational processes in place that enable the use of appropriately skilled, temporary (bank or agency) nursing.</p>
Director of Finance	<p>Ensures that the nurse staffing level is funded from the Health Board's revenue allocation and that it takes into account the actual salary points of staff employed on the wards where section 25B applies.</p>

Deputy Executive Director of Nursing	<p>Corporate support and consistency in the development of workload and workforce assessments;</p> <p>Provide support and training in the use of recognised methodologies in the development of annual workload and workforce assessments;</p> <p>Support the processing of vacancies that are in line with the annual workload and workforce assessments and are part of the agreed vacancy management plan for the area;</p> <p>Develop corporate reporting systems regarding staffing risks and concerns.</p>
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Nursing Management Structure

The Nursing Management Structure refers to all those nursing posts within the structure that sit between the ward sister / charge nurse and the Executive Director of Nursing.

7) Directors of Nursing	<p><u>Roles and responsibilities as outlined in – one to six below in addition:</u></p> <p>Responsible for the calculation of the nursing staff levels every six months at minimum, and when there is a change in service or use which is likely to change the nurse staffing levels and on an annual basis for all other areas, ensuring confirmation and challenge as part of the triangulation;</p> <p>Responsible for monitoring the professional standards in relation to the nurse staffing level at operational level and agreeing the nurse staffing levels for area of responsibility;</p> <p>Develop and implement a recruitment and retention plan for nursing in conjunction with workforce and organisational development;</p> <p>Ensure the Executive Director of Nursing and Midwifery as the 'designated person' is kept appraised;</p> <p>Present the six monthly staffing calculations to the Executive Director of Nursing and Midwifery, with the rationale for the calculation, and any variation or change to proposed staffing templates;</p> <p>Ensures any professional concerns regarding staffing, including vacancies, sickness absence and acuity, are</p>
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	<p>escalated accordingly and included on the divisional Risk Register.</p> <p>Request convening of the Nurse Staffing Levels Deployment meetings, if identified unmitigated staffing risks that require a Health Board wide response. The terms of reference and process / framework are included in Appendix eight.</p>
6) Head of Nursing	<p><u>Roles and responsibilities as outlined in one to five below - in addition:</u></p> <p>Provide professional leadership and guidance in the calculation of the nurse staffing levels and ensure all reasonable steps are taken in mitigating risk related to staffing levels;</p> <p>Review the patient acuity and quality indicator data and provide information that enables the Site / Area Director of Nursing to exercise professional judgement when calculating the nurse staffing levels;</p> <p>Ensure any staffing risks or concerns are managed appropriately and timely to ensure that patient care, safety, and nurses, are not compromised;</p> <p>Review monthly reports on nurse staffing levels, complaints and harm, and ensure reasonable steps are taken to manage risks in line with the reporting requirements of the Act.</p>
5) Matrons	<p><u>Roles and responsibilities as outlined in – one to three below in addition:</u></p> <p>Ensure effective and efficient use of nurse staffing resources to support safe, effective and fair advance planning by signing off the planner roster;</p> <p>Proactively manage daily workforce planning across areas of responsibility to ensure staff are distributed according to clinical need and patient acuity;</p> <p>Ensure daily acuity is completed within the SafeCare System / Health Care Monitoring System (for paediatric inpatient wards) and that staff understand their responsibilities on a daily basis in completing this;</p> <p>Ensure that on occasions where staffing is below agreed template an assessment is made as to whether the staffing negatively impacts on the patient experience /</p>

	<p>care provision using triangulation of acuity, professional judgement and quality indicators;</p> <p>Review all Datix reports and undertake final grading of all investigations and identify any trends or issues that arise and ensure that these are actioned.</p>
4) Clinical Site Manager	<p><u>Roles and responsibilities as outlined in one below - in addition:</u></p> <p>Maintain an overview of staffing and patient acuity across the site;</p> <p>At Safety Huddle / operational site meetings review staffing and agree reasonable steps to mitigate;</p> <p>Escalate staffing issues to the Head of Nursing or Bronze on call out of hours;</p> <p>Ensure that all “reasonable steps” are taken to maintain nurse staffing levels, including adjusting the nurse staffing levels to match the patient workload or changing the workload to match the nurse staffing level and step down of any surged beds;</p> <p>Ensure in the event of staffing being moved from other areas within the organisation that this is risk assessed and recorded within the SafeCare System (see Appendix four, Movement of Staff).</p>
3) Ward Manager	<p><u>Roles and responsibilities as outlined in one and two below - in addition:</u></p> <p>Undertake the bi-annual acuity audits for their ward and validate accuracy and completeness of the acuity data;</p> <p>Involved in the six monthly calculations and provide their professional opinion about the nurse staffing levels for their ward;</p> <p>Maintain the system for informing patients of the nurse staffing levels, ensuring the staffing board is kept updated;</p> <p>Ensures effective roster management in line with the rostering policy;</p> <p>Continuously assess the clinical environment and keep the Matron / Head of Nursing formally appraised of the situation;</p>

	<p>Ensure that all “reasonable steps” are undertaken to maintain the nurse staffing level and escalate any concerns;</p> <p>Review, record and report every occasion when the number of nurses deployed varies from the planned roster;</p> <p>Ensure mitigating actions are sufficient to maintain a safe service to both service users and staff.</p>
2) Nurse in Charge	<p><u>Roles and responsibilities as outlined in one below - In addition:</u></p> <p>Ensure that staff, bank and agency workers are moved in line with agreed principles.</p>
1) Registered Nurses	<p>Ensure own knowledge of this policy, the Act and the statutory guidance;</p> <p>Raise concerns with manager and on Datix when the nurse staffing levels have not been maintained;</p> <p>Awareness that all staff may be moved to another area to work, in line with their skills and competencies;</p> <p>Assess patient acuity on a daily basis using the Welsh Levels of Care for inclusion in the SafeCare System / Health Care Monitoring System (HCMS);</p> <p>Ensure risk assessment completed for patients requiring enhanced levels of care, in line with the policy.</p>

Operational Management Structures

The operational management structure relates to operational posts within the divisions and their responsibilities in line with the Act.

Divisional Management Team	<p>Ensure own knowledge of this policy, the Act and the statutory guidance and that these are applied to decision making for area of responsibility;</p> <p>Ensure budget setting takes account of the biannual staffing calculation requirements of the Act;</p> <p>Ensure that systems are in place to enable any required multi-disciplinary team learning, from individual as well as collated nurse-staffing related Datix reports within the service, ensuring trends identified and acted upon;</p>
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	<p>Ensure that Datix findings are an integral part of the governance assurance framework;</p> <p>Ensure that service planning (e.g. those within Integrated Medium Term Plan (IMTP)) takes account of the requirements set out in the Nurse Staffing Levels (Wales) Act;</p> <p>Ensure efficient and effective vacancy approval processes are in place within the Division / service to minimise delays within recruitment processes and escalate any delays that are outside the control of the operational team;</p> <p>Consideration of the temporary closure of beds and changes to the patient pathway as means through which to maintain nurse staffing levels where required.</p>
On Call Manager	<p>Ensure own knowledge of this policy, the Act, the statutory guidance applied to decision making out of hours;</p> <p>Ensure all reasonable steps are taken to maintain nurse staffing levels which would include:</p> <ul style="list-style-type: none"> ➤ supporting the Clinical Site Manager in adjusting the nurse staffing levels to match the patient workload; ➤ redeployment of staff; ➤ changing the workload to match the nurse staffing levels and step down of any surged beds; ➤ utilisation of bank/overtime, additional hours; ➤ approval for additional hours or agency in line with agreed control process. <p>Ensure all staffing decisions documented within on call log;</p> <p>Report staffing position risks and mitigation at conference calls and escalate concerns accordingly.</p>

6. CALCULATING THE NURSE STAFFING LEVEL

Triangulation

A triangulated approach is used for the calculation, utilising qualitative and quantitative information to determine the required nurse staffing level.



The triangulated approach takes account of the following:

Professional judgement

- The qualifications, competencies, skills and experience of the nurses providing care to patients;
- The effect of temporary staff on the nurse staffing level;
- The effect of a nurse's considerations of a patient's cultural needs;
- Conditions of a multi-professional team dynamic;
- The potential impact on nursing care of a ward's physical condition and layout;
- The turnover of patients receiving care and the overall bed occupancy;
- Care provided to patients by other staff or health professionals, such as health care support workers;
- Any requirements set by a regulator to support students and learners;
- The extent to which nurses providing care are required to undertake administrative functions;
- The complexity of the patient's needs in addition to their medical or surgical nursing needs, such as patients with learning disabilities;
- Specific consideration to the provision of care through the medium of Welsh;
- Professional judgement including: ward acuity, specialism and the care hours per patient day, location geography and layout of the ward.

Patient acuity

In line with the Welsh Levels of Care, acuity is defined as the measurement of the intensity of nursing care required by a patient. For the purpose of this work, the Health Board use the term acuity as an umbrella term which encompasses other terms such as dependency, intensity and complexity to describe the expanse of care that a patient requires based on their holistic needs.

The term acuity has two main attributes:

1. Severity, which indicates the physical and psychological status of the patient;
2. Intensity, which indicates the nursing needs, complexity of care and the corresponding workload required by a patient, or group of patients.

Adult: <https://heiw.nhs.wales/files/all-wales-nurse-staffing-programme/welsh-levels-of-care-edition-1/>

Paediatrics: <https://heiw.nhs.wales/files/all-wales-nurse-staffing-programme/draft-paediatric-welsh-levels-of-care/>

Quality indicators

Consider the quality indicators that are particularly sensitive to care provided by a nurse within Adult and Paediatric inpatient wards which include the following:

Adult

- Patient falls – any fall that a patient has experienced whilst on the ward;
- Pressure ulcers – total number of hospital acquired pressure ulcers judged to have developed while a patient is on the ward;
- Medication errors – any error in the preparation, administration or omission of medication by nursing staff (including medication related never events);
- Complaints – wholly or partially about care provided to patients by nurses, made in accordance with the complaints regulators.

Paediatrics:

- Medication administration errors;
- Pressure ulcers;
- Extravasation / infiltration injuries.

In addition, other quality indicators that may be deemed appropriate include:

- Patient experience;
- Unmet care needs;
- Failure to respond to patient deterioration;
- Staff well-being and ability to take annual leave;
- Staff compliance with mandatory training and performance appraisal development reviews.

A series of key documents have been published to support and guide staff within NHS Wales to meet the requirements of the Nurse Staffing Levels (Wales) Act and to prepare for the extension to other areas. These can be located on the following pages: [Documents - Nurse staffing programme - HEIW \(nhs.wales\)](#).

Frequency of Calculation

The routine bi-annual calculation of the nurse staffing levels should take place around March / April and August / September of each year. The timetable takes account of the All Wales bi-annual capture of acuity data, which occurs in January and June each year.

There may be occasions that require recalculation of the staffing levels outside of the bi-annual timetable. These factors are varied, with examples including:

- Exception reporting by the Ward Manager;
- High or consistent use of bank and agency workers;
- Prolonged inability to maintain the roster or consistent use of Ward Manager in the roster;
- Change of patient profile or skill mix / experience of staff;

- Concerns arising from negative patient feedback, complaints, incidents, harm dashboard and safeguarding.

The calculation of the nurse staffing level will be undertaken in partnership by the Ward Manager, Matron, Head of Nursing / Site Nursing Director and Finance Lead, with the available information triangulated to agree the proposed nurse staffing level for each ward.

The evidence and rationale used to determine the nurse staffing level must be recorded for each ward, outlining the rationale and the sources of information used to inform the triangulation approach. The All Wales Nurse Staffing Level Workforce planning template must be used (Appendix two).

Formal updates to the Board are presented in May and November each year. Once the Board have approved the bi-annual staffing calculations, the templates within E-Rostering will be updated in line with agreed Workforce and Organisational Development processes. Finance will align the budgets to the agreed staffing levels.

7. MAINTAINING THE NURSE STAFFING LEVEL

The Health Board will ensure all reasonable steps are taken to maintain the planned nurse staffing level on a shift by shift and long term basis.

Divisional teams will ensure effective roster management in line with agreed Roster Policy and robust systems which are in place for scrutiny and performance management of agreed Roster KPIs.

Corporate steps include:

- Workforce planning for a continued supply of required staff assessed using the Welsh Planning System;
- Active recruitment in a timely manner at local, regional, national, and international level;
- Retention strategies that include consideration of the NHS Wales Staff Survey results;
- Well-being at work strategies that support nurses in delivering their roles;
- Ensure strategic requirements of the Act are embedded into the organisation's IMTP / annual planning process;
- Robust workforce planning at ward / service level which are reviewed at least annually through IMTP / education commissioning processes;
- Workforce policies and procedures which support effective staff management (e.g. flexible working for staff);
- Robust organisational risk management framework.

Operational steps include:

- Changing shifts within existing establishment and cancelling study days, annual leave, administration days;
- Ward Manager working the shift as part of planned numbers;
- Creating additional hours in line with agreed Workforce and Organisational Development approval process;
- Looking at the wider multidisciplinary team to provide support;

- Re-allocation of staff across wards / departments / sites (see Appendix four Movement of Staff, and Paediatric Escalation Policy located here: <http://howis.wales.nhs.uk/sitesplus/861/opendoc/480540>);
- In line with agreed approval and booking processes:
 - Use of bank workers;
 - Offering overtime;
 - Use of agency workers.
- Consideration of changes to the patient pathway (which should be clinically appropriate);
- Convening of Nurse Staffing Levels Deployment Meeting if unmitigated staffing risks that require a Health Board wide response (Appendix seven);
- The temporary closure of beds (in line with agreed escalation processes to close beds).

Additional hours created above agreed roster template must have a clear rationale, evidenced by a risk assessment in line with the requirements of the Enhanced Care Policy (October 2019).

8. MONITORING AND RECORDING NURSE STAFFING LEVELS

SafeCare System for adult wards

The SafeCare Health Roster module provides an electronic view of staffing and patient acuity, enabling real time staff deployment to ensure safer and more efficient staffing levels. Information about the planned staff on duty is uploaded into the SafeCare module directly from the main Health Roster System. The Ward Manager, deputy or nurse in charge will identify appropriate levels of care for each patient based on the Welsh Levels of Care.

The Ward Manager, deputy or nurse in charge is responsible for accurately recording the staff on duty and patient acuity in the SafeCare Health Roster System. The data must be submitted at the agreed census period times in order to manage nurse-staffing levels on a shift by shift basis taking into account patient acuity.

For paediatric inpatient units this data is currently recorded on the Health Care Monitoring System (HCMS) until such time as the SafeCare System is adopted. Staff should refer to the HCMS guide V2 (Appendix seven).

When entering details of the staff on duty and the adult patient acuity, the Ward Manager, deputy or nurse in charge must review the information within SafeCare to ensure its accuracy. For paediatric inpatient wards, the Ward Manager, deputy or nurse in charge must review the data entered on to HCMS to ensure timely and accurate data collection.

Additional Duties

An additional duty is a duty that is above the agreed budgeted staffing requirement for the ward / service / department.

Additional duty requests must be discussed and authorised via the agreed channels. Each division / department will ensure they have in place an appropriate

staffing procedure that clearly documents the process to follow in the event of additional unbudgeted staffing being required. For example within nursing this would be via the Heads of Nursing in core hours and Silver on call out of hours. As part of the approval process the requirement for additional staffing should be appropriately evidenced to justify the requirement to staff above budget.

Those areas utilising the Rostering System must record any additional staffing requirements above the planned budgeted establishment / roster template as additional duties. Those areas not currently on the Rostering System should ensure they have a process in place to record additional staffing reasons and authorisation.

When entering additional duties into the Rostering System Managers must select the reason appropriate to the reason the duty is being utilised. Additional duty reasons and examples of times these maybe used, following appropriate approval, include:

- Enhanced care requirement - patients requiring enhanced care, this must be evidenced by appropriate risk assessments / care plans and be in line with relevant policies / procedures;
- Additional Service demand - additional and unplanned clinics / theatre lists / service activity;
- Escalated beds – beds opened above the budgeted ward establishment that require additional staffing to maintain patient safety;
- Supernumerary staff - staff on preceptorship, staff on phased return following a period of absence;
- Waiting List Initiative / Private Patient;
- SafeCare Redeployment.

Professional Judgement Level

When the levels of care have been entered onto the SafeCare System for adult wards, the Ward Manager, deputy or nurse in charge must review the shift rating in the system and if applicable enter a professional judgement level against this. Professional judgement levels within the system can be used to identify those shifts where the Ward Manager, deputy or nurse in charge has assessed and considers that, based on their professional judgement; the rating in the system requires amendment. The Ward Manager, deputy or nurse in charge is able to add professional judgement reasons to the system to both increase and decrease a shifts rating. The original rating will also be recorded within the system.

Red Flag Events

Red flag events are those occurrences stipulated by NICE (July 2014) which may be an indicator that the quality of care has declined and patients are vulnerable. Red flag events recommended for recording and reporting through SafeCare are:

Name	Description
Unplanned omission in providing medications.	Unplanned Omission in providing patient medications.
Delay in providing pain relief.	Delay of more than thirty minutes in providing pain relief.

Vital signs not assessed or recorded.	Patient vital signs not assessed or recorded as outlined in care plan.
Missed 'intentional rounding'.	Missed regular checks on patients to ensure that their fundamental care needs are met as outlined in the care plan. This involves checks on aspects of care such as describing pain levels, personal needs; item placement and patient positioning.
Less than two Registered Nurses (RNs) on shift	Less than two Registered Nurses present on a ward during any shift.
Shortfall in RN time.	A shortfall of more than eight hours or twenty five percent (whichever is reached first) of Registered Nurse time available compared with the actual requirement for the shift.
Mixed sex bays.	Mixed sex bays.
Nurse staffing levels below planned.	Nurse staffing levels below planned, based on the Nurse Staffing Levels (Wales) Act, calculations undertaken.
Hospital Acquired Pressure Ulcer (HAPU) Grade three+.	HAPU Grade three+.
HAPU Grade one / two.	HAPU Grade one / two.
Patient fall resulting in serious harm.	Patient fall resulting in serious harm.
Patient fall.	Patient fall.
Medication errors.	Medication errors.
Health care associated infections.	Health care associated infections.

Red flags can be raised and recorded on SafeCare by the nurse in charge. This must include the reason for raising the flag.

The Matron or Clinical Site Manager must also record on SafeCare the action taken to resolve a red flag event, as this is evidence of reasonable steps undertaken to manage staffing where template may be below requirements.

A red flag event requires escalation to Matron or Head of Nursing (in hours) and Clinical Site Manager or Bronze on call (out of hours) for an immediate review of patient safety and the mitigation of risk.

Health Board guidance relating to SafeCare can be accessed on the following link: <http://howis.wales.nhs.uk/sitesplus/861/searchresultssql/?q=safecare>.

Managing Staffing below Planned Staffing levels

The clinical environment is complex and managing staffing is a dynamic process; the planned roster therefore may be appropriately varied to respond to patients' dependency and acuity across the system. There will be occasions when the professional judgement indicates that it is appropriate to deviate from the planned

roster and the rationale for this should be documented within the SafeCare System / HCMS.

The escalation and documentation process outlined below details triggers, responsibilities and reasonable steps in the event staffing is below the planned roster, however staff should continue to use their professional judgment to interpret and apply the triggers as circumstances determine.

Green: No reported concern or compromise to patient care or safety as staffing hours available are in excess of the shift requirement.

Triggers: Red flags reviewed and mitigated, able to maintain the agreed staffing levels.

Action: Update SafeCare with staffing and acuity details. Add professional judgement and red flags. Ensure SafeCare updated if staff moved to support another area. Continue to monitor to ensure all areas staffed within agreed template and operational guidance.

Grey: staffing hours available are reflective of the shift requirement, with no staffing excess or short of hours according to patient acuity at the time of recording.

Triggers: Increased activity / dependency, unplanned absence, one shift in twenty four hours not covered, staffing template maintained however skill mix, competency, qualifications or experience not suitable for care needs.

Action:

- Ensure **Green** action plan and risks identified are completed;
- Document within SafeCare;
- Review and cancel management time, planned time off in lieu (TOIL), study leave;
- Redeploy internal staffing resources based on SafeCare;
- Use additional or unused hours, send shifts to bank;
- Escalate to Matron / Clinical Site Manager.

Amber: staffing hours available are one to six hours below the shift requirement based on the staffing hours and patient acuity recorded. Risk of patient care being compromised, impacting on the patients' required care interventions (medication, observation, input or output), progress, outcomes, or dignity.

Triggers: Multiple shifts not staffed to agreed level but to a level that meets the current patient / acuity or service demand, shortfall of twenty five percent RN time available for requirement of shift and skill mix is not met.

Action:

- Ensure **Grey** action plan and risks identified completed;
- Escalate to Head of Nursing (Bronze out of hours) and review staffing across service area;
- Ask other care groups to review rotas and workload;

- Review ability to redeploy across wards / departments based on SafeCare including Matrons, specialists nurses and educators;
- Short notice leave cancelled including TOIL and, potentially, annual leave;
- Offer overtime and request Agency authorisation;
- Report shortage and contingency plan at Safety Huddle / operational site meetings;
- Update SafeCare ensuring reasonable steps undertaken to mitigate risks recorded.

Red: Reported concern over the nurse staffing level - staffing hours available are more than 7 hours below the shift requirement, based on the staffing hours and patient acuity recorded.

Triggers: Significant or ongoing shifts not staffed to agreed level; compromised ability to safely meet current acuity, dependencies or complexity; less than fifty percent RN time; skill mix not met; Inability to de-escalate from high risk (amber) after twenty four hours.

Action:

- Ensure **Amber** action plan and risks identified completed;
- Escalate to Director of Nursing (Silver on call out of hours);
- Director of Nursing (Silver on call) considers (in line with operational escalation plans);
 - Temporary partial bed closure;
 - Cancellation of non-urgent electives;
 - Cancellation of outpatient activity;
 - Cross-organisation response and support;
 - Convening of Nurse Staffing Levels Deployment meeting if unmitigated staffing risks that require a Health Board wide response (Appendix eight);
 - Divert options;
 - Update SafeCare and report on Datix and feedback outcome to Head of Nursing / Bronze on call;
 - Urgent implementation of plan to de-escalate staffing concerns;
 - Agree and document plan and timescales for recovery / de-escalation and document;
 - Escalate to Deputy Director Nursing / Executive Directors of Nursing and Midwifery (Gold on call out of Hours).

NB. For paediatric wards entering data on to HCMS, staff must record whether the number of staff on duty were appropriate to be able to meet patient's care needs. The escalation process for staffing is detailed in the paediatric escalation policy that can be accessed here: [Betsi Cadwaladr University Health Board | Paediatric escalation policy \(wales.nhs.uk\)](https://www.betsi-nhs.uk/paediatic-escalation-policy).

9. TRAINING

The E-Rostering team will provide initial, and any update, training on the use of the SafeCare System. This will include Train the Trainer so that identified ward / department staff can continue training. Training on staffing and acuity is also

included within the Ward Manager / Matrons development training programmes and twice yearly by the All Wales Nurse Staffing Lead.

Cascade training is in place within the paediatric wards for induction / refresher training on all aspects of the Nurse Staffing Levels (Wales) Act, including staffing and acuity.

10. MONITORING AND REPORTING

All incidents related to safe staffing, or harms where safe staffing levels was a potential factor, must be escalated through the line management arrangements and reported on Datix, which includes mandatory questions on staffing levels.

Monthly divisional staffing reports include triangulation of nurse sensitive indicators, and quality indicators where staffing has fallen below planned levels, to identify the impact on care of not maintaining the nurse staffing levels (Appendix three). Staffing reports are presented to Division and Corporate Quality and Safety groups in line with the agreed reporting cycle.

The Complaints System includes a series of questions to enable triangulation of staffing information and actions taken, where complaints are wholly or partially attributable to nursing care. On closure of the complaint, professional judgement is used to ascertain if inability to mitigate / maintain staffing levels had an impact on the care provided and the resulting impact and actions taken as a result.

The templates for Health Board's assurance and reporting requirements under the Act in May and November each year are included within Appendix five (i) and (ii) May report and Appendix six (i) and (ii) November report. Non-compliance with the Act are considered under the Joint Escalation and Intervention Arrangements (2014) undertaken twice yearly by the Welsh Government, the Wales Audit Office and the Healthcare Inspectorate Wales.

11. IMPLEMENTATION

Following its approval the policy will be distributed electronically via the Professional Advisory Group, divisional operational teams, Bulletin, relevant Health Board policies page and will be listed as an agenda item on all operational / nursing / department meetings so that all staff are aware of its existence, content and their personal role responsibilities required to adhere to it. Any training needs identified should be fed back via the service structure and arrangements should be made to meet these needs as quickly as possible to ensure comprehensive and consistent implementation of the policy.

12. INFORMING PATIENTS AND THE PUBLIC

The Health Board will inform patients and the public about planned staffing levels by displaying this information, with the date approved, on staffing boards, which are located at the entrance to each ward / department. Bilingual leaflets and posters for patients, relatives and carers about the Nurse Staffing Levels (Wales) Act are also available and will be provided in format that is appropriate to the patient's individual circumstances, (i.e. age) to ensure patient understanding.

13. EQUALITY, WELL-BEING AND THE ENVIRONMENT

An Equality Impact Assessment has been completed and is included with no

anticipated adverse impact.

14. REVIEW

This policy will be reviewed within three years, or sooner, following updated All Wales guidance or the extension of the settings covered by the Act by Welsh Ministers.

15. FURTHER INFORMATION

Berwick (2013) *A promise to learn a commitment to act. Improving the Safety of Patients in England*. National Advisory Group on the Safety of Patients in England.

Francis (2013) *Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry* London. The Stationary Office.

Keogh Review (2013) *into the quality of care and treatment provided by 14 hospital Trusts in England*. NHS England.

National Escalation Process and Action Plans 2014, Welsh Government.

NICE (2014) *Safe Staffing for Nursing in Adult Inpatient Wards in Acute Hospitals*. NICE.

NMC (2015) *The Code: Professional Standards of Practice and Behaviour for Nurses and Midwives*.

Welsh Government (2016) *Nurse Staffing Levels (Wales) Act*.

16. APPENDICES

Appendix one: Definition Adult Acute Medical and Surgical Wards / and Inpatient Paediatric Wards

Adult acute medical inpatient ward	<p>An area where patients aged eighteen or over receive active treatment for an acute injury or illness requiring either planned or urgent medical intervention, provided by, or under, the supervision of a consultant physician.</p> <p>Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant and / or their team, and / or advanced practitioners for their acute injury or illness.</p>
Adult acute surgical inpatient ward	<p>An area where patients aged eighteen or over receive active treatment for an acute injury or illness requiring either planned or urgent surgical intervention, provided by, or under, the supervision of a consultant surgeon.</p>

	Patients are deemed to be receiving active treatment if they are undergoing interventions prescribed by the consultant and / or their team, and / or advanced practitioners for their acute injury or illness.
Paediatric inpatient ward	<p>An area where patients receive active treatment for an injury or illness requiring either planned or urgent medical or surgical intervention, provided by, or under the supervision of a consultant physician or surgeon.</p> <p>Patients on these wards will be aged zero to seventeen however individuals up to their eighteenth birthdays may receive treatment in an adult inpatient ward on occasions where professional judgement deems it to be more appropriate based on the clinical needs of the patient while also taking into consideration the existing risk assessment protocols as well as the right of the child / guardian to take part in the decision.</p> <p>Patients are deemed to be receiving active treatment if they are undergoing intervention(s) for their injury or illness prescribed by the consultant, and / or their team, and / or advanced practitioners</p>

NB: a full glossary is available from [Documents - Nurse staffing programme - HEIW \(nhs.wales\)](#).

Appendix two: Nurse Staffing Levels Workforce Planning template

Attached separately.

Appendix three: Triangulation of Patient Harm Incidents Report

Attached separately.

Appendix four: Movement of Staff

Attached separately

Appendix five: May Reports:

(i) Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act;

Attached separately

(ii) Appendix: Template for presenting Nurse Staffing Levels to the Board

Attached separately

Appendix six: November Reports:

(i) Annual Presentation of Nurse Staffing Levels to the Board;

Attached separately

(ii) Appendix: Summary of Nurse Staffing Levels for 25B wards.

Attached separately.

Appendix seven: Health Care Monitoring System (HCMS) User Guide

Attached separately

Appendix eight: Nurse Staffing Levels Deployment Escalation Meeting (Terms of Reference / Agenda / Situation Reporting/Minutes).

Attached separately.

Appendix nine: All Wales Paediatric Calculation Template

Attached separately

Consultation

Title	Date
Heads of Nursing, Glan Clwyd / Ysbyty Gwynedd and Wrexham.	May 2019
E-Roster Manager.	May / September 2019
Secondary Care Nurse Director.	May / August / September 2019
Deputy Director of Nursing.	May / August / September 2019
Interim Executive Director of Nursing and Midwifery.	September 2019
Nurse Directors, Glan Clwyd / Ysbyty Gwynedd / Wrexham.	September 2019
Nurse Directors, Area West / Area Central / Area East.	September 2019
Director Midwifery and Women's Services.	September 2019
Associate Director of Nursing / Infection Prevention / Safeguarding / Quality.	September 2019
Head of Patient Safety Incidents, Corporate Nursing.	September 2019
Paediatric Service Manager, Central; Paediatric and Neonatal Service Manager, East; Head of Nursing, Children's Services, Central; Clinical Service Manager Paediatrics And Neonatal, West.	September 2019
Head of Human Resources - Corporate Services and Specialist Advice.	September 2019
Associate Director Workforce Performance & Improvement.	September 2019
Interim Head of Resourcing.	September 2019
Professional Advisory Group.	October 2019
Paediatric Staffing Implementation Group.	April 2021
E Roster Manager.	April 2021
Nursing Recruitment and Retention Group.	May 2021
Clinical Policies Group.	November 2021
Patient Safety and Quality Group	December 2021

Nurse Staffing Levels Policy: Appendices One - Nine

	Document
Appendix one: Definition Adult Acute Medical and Surgical Wards / and Inpatient Paediatric Wards	Definition located on page 20 of Nurse Staffing Levels Policy
Appendix two: Nurse Staffing Levels Workforce Planning Template	 Nurse Staffing Levels Workforce Pl
Appendix three: Triangulation of Patient Harm Incidents Report	 Triangulation of Patient Harms Incide
Appendix four: Movement of Staff	 Staff Movement
Appendix five: May Reports: (i) Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (ii) Appendix: Template for presenting Nurse Staffing Levels to the Board	 Annual Assurance Report on complian  Template for presenting Nurse St
Appendix six: November Reports: (i) Annual Presentation of Nurse Staffing Levels to the Board (ii) Appendix: Summary of Nurse Staffing Levels for wards where Section 25B applies	 Annual Presentation of Nur:  Appendix: Summary of Wards where seci
Appendix seven: Health Care Monitoring System (HCMS) All Wales HCMS User Guide	 HCMS user guide.pdf
Appendix eight: Nurse Staffing Levels Deployment Escalation Meeting (Terms of Reference / Agenda / Situation Reporting/Minutes).	 Appendix 8 Nurse Staffing Levels Depl
Appendix nine: All Wales Paediatric Calculation Template	 PAEDIATRIC CALCULATION TEMPI



GIG
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NHS
WALES

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

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

<u>For:</u>	Nurse Staffing Levels Policy
<u>Date form completed:</u>	<i>25.10.19 updated 24.9.21</i>



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?	Nurse Staffing Levels Policy
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The Nurse Staffing Levels Policy approved in 2020 has been updated to include the extension of the Act for Paediatrics and other all Wales documents
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?	Executive Director of Nursing and Midwifery as the ‘designated person’ under the Nurse Staffing levels (Wales) Act
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	<p>Nurse Staffing Levels Wales Act (2016) Statutory guidance Welsh Government; <u>Nurse staffing levels: statutory guidance for health boards and NHS Trusts GOV.WALES</u></p> <p>Nurse Staffing Levels (Wales) Act 2016; <u>Nurse Staffing Levels (Wales) Act 2016 (legislation.gov.uk)</u></p> <p>All Wales Nurse Staffing levels – Key Documents <u>Documents - Nurse staffing programme - HEIW (nhs.wales)</u></p> <p>OP01 BCUHB Protocol for the Management of Emergency Pressures and Escalation (2015); <u>http://howis.wales.nhs.uk/sitesplus/861/document/361746</u></p> <p>GC04 BCUHB Operational Scheme of Delegation; <u>http://howis.wales.nhs.uk/sitesplus/861/document/417366</u></p>

Part A

Form 1: Preparation

Please answer all questions

		Paediatrics Escalation Policy - http://howis.wales.nhs.uk/sitesplus/861/opensdoc/480540
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	Employees, the Board, patients and service users.
6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	Use of SafeCare Roster System as outlined in the document. Communication and training will help in the implementation of the policy. Communication would be via existing management structures, and the revised policy will be communicated via the internal bulletin. Training would be via divisions and corporate teams such as E Roster team for SafeCare.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The policy will help ensure improved outcomes for service users by putting in place a framework to support appropriate staffing for high quality care. Provision of high quality care requires the right people, in the right place, with the right skills at the right time to ensure the best health and care outcomes for service users. The policy will also support and empower staff decision making in relating to staffing decisions in line with the requirements of the Nurse Staffing Levels (Wales) Act

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

Part A

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

Please answer all questions

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

Part A

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

Please answer all questions

<p>NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect.</p> <p>For the definitions of each characteristic please click here</p>						
	Yes	No	(+ve)	(-ve)		
Age	√		√		Promote a safe working environment for staff. For patients staffing decisions take account of acuity and dependency of patients which may or may not be age related, staffing policy will support quality of care and meeting each person's needs. The Nurse Staffing Levels Policy approved in 2020 has been updated to include the extension of the Act for Paediatrics in addition to other all Wales documents. This update to the policy therefore ensures that measures are in place to assure quality of care for all patients regardless of age.	<i>No negative impacts identified.</i>
Disability	√		√		People with a disability will be affected positively if staffing levels increase. For staff, reasonable adjustment in the workplace would apply in line with Guidance (WP27 and WP11 Managing Attendance at Work Policy). The complexity of patient needs, including disability would be identified as part of the triangulation approach of acuity assessment, professional judgment and local context, therefore resulting in a positive impact on patients with complex needs/ disability.	<i>No negative impacts identified.</i>

Part A

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

Please answer all questions

Gender Reassignment		√			Staffing policy applicable regardless of gender of staff or patients. The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016, requiring organisations to calculate and monitor the number of nurses required to sensitively care for patients.	<i>Staff are expected to be mindful of issues often experienced by transgender individuals that may require more complex support or sensitivity</i>
Pregnancy and maternity	√		√		Pregnant women or those with caring responsibilities would be eligible to submit requests for flexible working if the policy impacted on personal circumstances. The complexity of the caring needs of pregnant women would be identified as part of the triangulation approach of acuity assessment, professional judgment and local context, therefore resulting in a positive impact on patients who are pregnant.	<i>No negative impacts identified.</i>
Race	√		√		Cultural needs and medical requirements potentially arising from an illness typically affecting patients from particular ethnic backgrounds (e.g. sickle cell) would be identified as part of the holistic assessment of care, triangulated with acuity and professional judgement.	<i>No negative impacts identified.</i>
Religion, belief and non-belief	√		√		Religions, belief or non-belief would be assessed as part of the triangulation approach to calculating staffing requirements.	<i>No negative impacts identified.</i>
Sex	√		√		Higher proportion of the nursing and midwifery workforce are female, the policy would promote a safe working	<i>No negative impacts identified.</i>

Part A

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

Please answer all questions

					environment for staff, positive impact if staffing levels increase.	
Sexual orientation			√		<p>As part of the triangulation approach of acuity assessment, professional judgment and local context, the needs of patients would be assessed regardless of sexual orientation. The Nurse Staffing Level (Wales) Act 2016 became law in Wales in March 2016, requiring organisations to calculate and monitor the number of nurses required to sensitively care for patients.</p> <p>Studies suggest that LGBTQ+ individuals suffer more mental health issues: LGBTQ+ Research - Student Minds and also discrimination in healthcare and substance abuse issues Why is the LGBTQ+ community disproportionately affected by mental health problems and suicide? News and Events Greater Manchester Mental Health NHS FT (gmmh.nhs.uk)</p>	<i>Staff are expected to be mindful of issues often experienced by LGBTQ+ individuals that may require more complex support or sensitivity</i>
Marriage and civil Partnership (Marital status)			√		Not anticipated would impact on marriage or civil partnership.	<i>No negative impacts identified.</i>
Socio Economic Disadvantage			√		Not anticipated would influence socio economic disadvantaged. Staffing requests would be submitted in line with health board roster and flexible working policy.	<i>No negative impacts identified.</i>

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)			
√		√		Article 3 - Prohibition of inhuman or degrading treatment Article 8 - Right to respect for family & private life	The policy would support improved outcomes for service users by putting in place a framework to support appropriate staffing for high quality care. Fundamentals of Care and all Nursing processes and professional expectations remain in place.	<i>No negative impacts identified.</i>

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	√		√		Uniforms display Welsh Language Speaker logo for those that are able to converse with patients and colleagues in Welsh. Welsh language classes are available to staff that may wish to learn.	N/A
Treating the Welsh language no less favourably than the English language	√		√		Information for patients relating to the Nurse Staffing Act will be bilingual in line with Health Board policy.	N/A

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

<p>What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods.</p> <p><i>for further direction on how to complete this section please click here training vid p13-18</i></p>	<p><i>Original policy circulated widely within BCUHB, approved at Quality and Safety group and then at Quality and Safety Executive Committee.</i></p>
<p>Have any themes emerged? Describe them here.</p>	<p>No themes identified</p>
<p>If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?</p>	<p>Any comments with respect to the policy have been reviewed and either noted or the policy amended</p>

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) <i>for further direction on how to complete this section please click here training vid p13-18</i>	Nurse Staffing Levels Policy
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2. Brief Aims and Objectives: (Copy from Form 1)	The Nurse Staffing Levels Policy approved in 2020 has been updated to include the extension of the Act for Paediatrics and other all Wales documents
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From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? Guidance: This is as indicated on form 2 and 3	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	<i>The EqIA has not identified an adverse impact. The policy will have a positive impact as the provision of appropriate staffing will help ensure quality of care across settings, meeting each person's needs. It will also promote a safe working environment for staff and ensure staffing decisions take account of contextual factors. The policy is intended to apply equally to those affected by its provisions, however acknowledges that everyone is different</i>	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes <input type="checkbox"/>	<input checked="" type="checkbox"/>
	No anticipated negative impact, the policy provides definition of responsibilities, escalation, monitoring and reporting requirements.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	How is it being monitored?	<i>SafeCare system, E Rostering, Harms Dashboard, Staffing reports, secondary care submit monthly report and quarterly report re staffing levels Act to the Board</i>
	Who is responsible?	Site and Area Directors of Nursing with escalation accordingly to Executive Director of Nursing and Midwifery as outlined within the Policy
	What information is being used?	Staffing information, Datix, Complaints, Incidents, Patient Experience

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	When will the EqIA be reviewed?	3 years
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7. Where will your policy or proposal be forwarded for approval?	<i>Clinical Policies Group/</i> Quality, Safety and Experience Committee
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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
	Anne-Marie, Rowlands,	Associate Director Professional Regulation & Education
	<u>2019</u> Debra Hickman, Julie Smith, Alison Griffiths, Mandy Jones, Naomi Holder, Fiona Giraud,	Secondary Care Nurse Director; Associate Director Quality; Nurse Director; Nurse Director; Nurse Director; Director of Midwifery and Womens Services
	<u>2021</u> Members Members	Paediatric Staffing Group Nursing Recruitment and Retention Group
	<u>2019</u> Mike Townson, <u>2021</u> Nick Such	Senior Equalities Manager Equality and Inclusion Manager (Workforce)

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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:	N/A	N/A	N/A
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	N/A	N/A	N/A

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?	N/A	N/A	N/A
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A	N/A	N/A
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A	N/A	N/A