Bundle Quality, Safety & Experience Committee 6 September 2022

1 OPENING ADMINISTRATION

1.1 QS22.229 - Welcome, introductions and apologies for absence - Chair - Information - Verbal Report

1.2 QS22.230 - Declarations of interest on current agenda - Chair - Decision - Verbal Report

1.3 QS22.231 - Minutes of last meeting – 5 July 2022 - Chair - Decision - Paper

22.231 - QSE Minutes 05.07.22 V0.2 LR amends.doc

1.4 QS22.232 -Action log - Chair - Decision - Paper

22.232 - Summary Action Log QSE Public - Revised 26.08.22.docx

1.5 QS22.233 - Patient Story Executive Director of Nursing & Midwifery - Assurance - Video

22.233 - APPROVED - Patient Story - QSE - Sept 2022.docx

1.6 QS22.234 - Report of the Lead Executive Executive Director of Nursing & Midwifery - Information - Paper

22.234 - APPROVED - Lead Executive Report - QSE - Sept 2022.docx

2 STRATEGY AND POLICY

2.1 QS22.235 - Quality aspects of IMTP Executive Director Transformation, Strategic Planning and Commissioning - Assurance - Paper

22.235 - QSE report Quality Aspects of the Annual Plan IMTP September 2022 DRAFT v1.docx

2.2 QS22.236 - Board Assurance Framework Quality Aspects - Board Secretary - Assurance - Paper

22.236 - QSE BAF Cover.docx

2.3 QS22.237 - Corporate Risk Register - Executive Medical Director - Assurance - Paper

22.237 - DRAFT QSE Committee Coversheet - Corporate Risk Register v1.0.docx

22.237 - Appendix 1 - Quality, Safety and Experience Committee Corporate Risk Register.pdf

22.237 - Appendix 2 - Full List Corporate Risks V.9.pdf

22.237 - Appendix 3 - Corporate Risk Register Risk Key Field Guidance V2-Final.pdf

3 QUALITY SAFETY AND IMPROVEMENT

3.1 QS22.238 - Mental Health Outcomes and Improvements - Executive Director of Public Health - Assurance - Paper

22.238 - MHLD Divisional Improvement Plan Board Report v0.6 FINAL.docx

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Example Plan on a Page (002).pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Example Power BI Dashboard.pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL House.pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Improvement Plan Navigation.pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Phases.pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Tier 1 - Workstreams.pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Tier 2 - Sub-themes.pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Tier 3 - Task level detail.pdf

22.238 - 220825 MHLD Div Imp Plan V18 FINAL Timescales.pdf

22.238 - 220825 MHLD Div Imp Plan V18 KPIs.pdf

22.238 - MH&LD Slide deck DIP v0.5 DRAFT,.pptx

3.2 QS22.239 - YGC Improvement Plan Include the HIW Action Plan - Deputy CEO/Executive Director Of Integrated Clinical Services/ Executive Director Transformation, Strategic Planning, And Commissioning/ Programme Director Clinical Safety Improvement - Assurance - Paper

22.239 - YGC Improvement Plan.docx

3.3 QS22.240 - Vascular Improvement Plan - Executive Medical Director - Assurance - Paper

22.240 - Vascular QSE Paper 6 Sep 22.docx

22.240 - Appendix 2 QSE Vascular Sep 6 22.pdf

3.4 QS22.241 - Urology Improvement Plan - Deputy CEO/Executive Director Of Integrated Clinical Services Assurance Paper

3.5 QS22.242 - Quality & Performance Report - Executive Director of Finance - Assurance - Paper

22.242 - QSE cover - September 2022 (July Data)v2.docx

22.242 - QP Report QSE - Sept 2022 (July 2022 Position)v3.pdf

3.6 QS22.243 - Patient Safety Report - Executive Director of Nursing & Midwifery - Assurance - Paper

22.243 - APPROVED - PS Report - QSE Sept 2022.docx

3.8 QS22.244- Patient & Carer Experience Report Executive Director of Nursing & Midwifery Assurance Paper

22.244 - APPROVED - PCE Report - QSE - Sept 2022.docx

3.9 QS22.245 - Quality/Safety Awards and Achievements Executive Director of Nursing & Midwifery Consent Paper

22.245 - APPROVED - Quality Achievements - QSE - Sept 2022.docx

3.10 QS22.246 - Health & Safety Executive Compliance Update Executive Director of Workforce and Organisational Development Information Paper

22.246 - 2022_09_06 HSE Notice of Contravention Public v.3.docx

3.11 QS22.247 - Mortality Review Update - Executive Medical Director - Assurance - Paper

22.247 - QSE Mortality and ME paper.docx

4 REPORTING

4.1 QS22.248 - Chair's Assurance Reports from Strategic and Tactical Delivery Groups • Lead Executives Consent Paper

22.248a - APPROVED - PCE Chair Report - QSE - Sept 2022.doc

22.248b - SOH Chairs Assurance Report.doc

22.248c - APPROVED - PSQ Chair Report - QSE - Sept 2022.doc

22.248d - IPSG Committee Chair's Assurance Report for QSE from July 22 meeting.docx

4.2 QS22.249 - HMP Berwyn – Annual Report Deputy CEO/Executive Director Of Integrated Clinical Services - Consent - Paper

22.249 - QSE Cover sheet September 2022 HMP Berwyn Annual report Agenda item 4.2 Board Committee.docx

22.249a - HMP Berwyn Annual Report 2022.pdf

4.3 QS22.250 - Safeguarding Annual Report Deputy CEO/Executive Director Of Integrated Clinical Services - Information - Paper

22.250 - Exec Summary Corporate Safeguarding Annual Report 2021-2022 V6.00.docx

22.250a - Corporate Safeguarding Annual Report 2021-2022 V1.00.docx

4.4 QS22.251 - Regulation 28 Update Executive Director of Nursing & Midwifery - Assurance - Paper

22.251 - APPROVED - R28 - QSE - Sept 2022 (005).docx

4.5 QS22.252 - Infection Prevention Annual Report Executive Director of Nursing & Midwifery - Assurance - Paper

22.252 - Board Committee Coversheet for IP Annual Report 21_22.docx

22.252 - IPC Annual Report 2021_22 Final.pdf

22.252 - SCC-HF Annual Report 2021-22 v1.0 FINAL.pdf

4.6 QS22.253 - HIW Update Executive Director of Nursing & Midwifery - Assurance - Paper

22.253 - APPROVED - Healthcare Inspectorate Wales - QSE - Sept 2022.docx

22.253 - APPROVED - Healthcare Inspectorate Wales - Appendix - QSE - Sept 2022.pdf

5 CLOSING BUSINESS

5.1 QS22.254 - Issues Discussed in Previous Private Session Chair - Assurance - Paper

5.2 QS22.255 - Date of Next Meeting 1 November 2022 Chair - Information - Verbal

5.3 QS22.256 - Exclusion of Press and Public Chair Information - Verbal - Report

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 6 July 2022
Via Teams

Present:

Lucy Reid	Independent Member (Chair)
Cheryl	Independent Member
Jackie Hughes	Independent Member
John Gallanders	

In Attendance:

Gareth Evans	Acting Executive Director Of Therapies & Health Science
Sue Green	Executive Director of Workforce and Organisational Development
Gill Harris	Executive Director of Integrated Clinical Delivery/Deputy Chief Executive
Dave Harris	Internal Audit
Matthew Joyes	Acting Associate Director of Quality Assurance
Fleur Jones	Audit Wales
Nick Lyons	Executive Medical Director
Molly Marcu	Interim Board Secretary
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Chris Stockport	Executive Director of Transformation, Strategic Planning and Commissioning
Mike Smith	Interim Director Of Nursing Mental Health
Gaynor Thomason	Acting Executive Director for Nursing and Midwifery
Patrick Hill	Deputy Director Medical Physics
Amanda Lonsdale	Director Of Performance, Performance Directorate

Agenda **Action**	**Item**
QS22/111 Apologies for Absence **QS22/111.1** Apologies were received from Hugh Evans, Adrian Thomas	
QS22/112 Declarations of Interest **QS22/112.1** No declarations of interest were raised.	
QS22/113 Minutes of Previous Meeting Held in Public for Accuracy **QS22/113.1 It was resolved that** the minutes were approved as an accurate record of the meeting held on 3 May 2022.	

QS22/114 Matters Arising and Table of Actions **QS22/114.1** The Committee reviewed the action log and closed actions where appropriate. **QS22/114.2** The Acting Executive Director Of Therapies & Health Science advised that he would split action 10 given that the Psychological Therapies Report had been removed from the website but the action to reconcile between the outcome of the actions against the original report had not been concluded.	GE
QS22/115 Patient Story **QS22/115.1** The Committee received an account from the mother whose daughter had attended Emergency Department at Glan Clwyd Hospital following a bad fall. The Committee noted that the fall had resulted in obvious facial fractures and had left her daughter in an extremely distressed and agitated state. As a registered health professional, she knew her daughter needed urgent medical attention and took her straight to the Emergency Department where they both received exemplary treatment. The Committee noted that the staff she encountered including Security Guards, Emergency Department, ENT and Maxfax clinicians, were conscientious and thorough but still delivered care with kindness and compassion to both her daughter and herself. **QS22/115.2** The Acting Associate Director of Quality Assurance highlighted the positive feedback, that the care received was person centred, sensitive and respectful throughout. It was noted that the positive feedback had been shared with all the relevant departments. **QS22/115.3** An Independent Member queried the age of the patient and the Acting Associate Director of Quality Assurance advised that he did not know their age exactly but believed that they were a young adult. **QS22/115.4** An Independent Member noted that he would have liked to hear what followed, for example, what was their experience with outpatients. **QS22/115.5** The Chair asked whether the reasons why this patient's experience had been so positive in comparison to others that are recounted had been looked at. She wanted to know what had been different on that day, and if there had been a specific clinical lead around for example, so the department could reflect on why this had gone so well. The Acting Associate Director of Quality Assurance advised that what had come across very clearly was that staff took the time to listen and that it was quite difficult to share compassion, but that this time, despite being very busy, staff had gone the extra mile. **QS22/115.6** The Acting Executive Director for Nursing and Midwifery advised that going forward themes and action plans would be created to understand the circumstances around experiences shared. **QS22/115.7 It was resolved that** the Committee receive and reflect upon the story	MJ

QS22/116 Report of the Lead Executive **QS22/116.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive presented her report highlighting that a new Director of Governance would be starting with the Health Board in the coming weeks and that they would be asked to take a piece of work forwards around the Ockenden and HASCAS reports ensuring that actions have been embedded. **QS22/116.2** An Independent Member queried if month end figures being shared at Committees was causing a delay in reporting events such as Regulation 28 notices or Never Events in a timely way and queried the coronial process and what was causing the delays with that. It was noted that Never Events are shared with the Board once reviews have taken place. The Acting Associate Director of Quality Assurance gave a brief update on a recent Never Event noting that a rapid learning session had taken place that morning following the wrong size implement being used in a joint replacement and that the event would be taken forward through the rapid review process. It was agreed to discuss the matter further in the Private Session. **QS22/116.3** The Acting Associate Director of Quality Assurance advised that the challenge was around completing the final report to the Coroner. The Executive Medical Director advised that a monthly look ahead had been established on Coroner's Inquests and that a weekly update was being received on the Tawel Fan Inquests. With regards to delays in Inquests it was noted that there was a back log with the Coroner due to Covid restrictions, however, when the Coroner raises further questions it is often necessary to repeat the process again. **QS22/116.4** The Executive Director of Workforce and Organisational Development advised that when managers are giving statements in good faith they should be supported to do so. She suggested that it would be helpful to jointly plan work with the Health and Safety Executive (HSE) as the regulator would jointly work with both the Coroner's Office and the HSE. **QS22/116.5** An Independent Member clarified that the report being discussed covered the period up to the end of May and queried if it would it be possible to do a pre-emptive report to be produced ahead of any Inquest. The Executive Medical Director advised that further work was required with regards to record keeping but that sometimes it was difficult to anticipate what the Coroner would ask but that learning from best practice elsewhere could help. **QS22/116.6** The Acting Associate Director of Quality Assurance clarified the Coronial process noting that Inquests should be completed within six months. It was noted that what is currently occurring is that the media are attending all inquest hearings which is unusual. **QS22/116.7** The Chair noted that this would be picked up in the private session and that a report in the public meeting would be received at the meeting in September 2022.	SG

QS22/116.8 It was resolved that the Committee received the report. [Patrick Hill joined the meeting]	
Strategy and Policy	
QS22/117 Community Health Council Speech and Language Therapy Report **QS22/117.1** The Acting Executive Director Of Therapies and Health Science presented the report noting that it was on the agenda as a consent item. The themes identified in the report were highlighted as user involvement in service planning and improvement, improvement in the number of Welsh speaking practitioners and improvements in general access to the service and wait times. It was highlighted that the review had been undertaken during Covid and that the recovery plan for speech and language following Covid aligns to the report. **QS22/117.2** The Chair of the North Wales Community Health Council advised that it would be helpful to repeat the safe space event given that the report was undertaken during the Covid pandemic. **QS22/117.3** An Independent Member noted that it was distressing to read that parents were fighting to get into the service. A discussion took place around workforce and that courses being run in North Wales were able to be delivered in both Welsh and English and that there was interest in setting up a post graduate speech and language course. **QS22/117.4** A discussion took place around wait times noting that targets being highlighted were Welsh Government targets and that the wait times for the provision for new patients had improved. It was noted that more dynamic reporting was required rather than being so heavily reliant on Welsh Government targets. **QS22/117.5 It was resolved** that the Committee considered the findings of the NWCHC report and the service plan to address the identified learning points.	
QS22/118 Discharge Standard Operating Procedure **QS22/118.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive clarified the reason the Committee were receiving the Discharge Standard Operating Procedure (SOP). It was noted that the SOP had been produced to pre-empt the policy that was being drafted and that it was required due to procedures being inconsistent across the Health Board. **QS22/118.2** An Independent Member welcomed the consistent approach across the Health Board and commented that on page five of the document family should be referenced and that clarification around the meaning of transport was required at the end of section four. **QS22/118.3** A discussion took place around who would discharge the patient, the Committee noted that a discharge professional was being identified. The	

Committee discussed what happened if there was a delay in a patient being admitted and it was noted that why patients were leaving was being reviewed to ensure that they are not leaving at risk. It was agreed that the Executive Director of Integrated Clinical Delivery/Deputy Chief Executive, Executive Medical Director and the Acting Executive Director for Nursing and Midwifery would pick up a piece of work around team working and appropriate leadership and that a form of words would be included in the SOP around this area. **QS22/118.4** The Chair raised lasting power of attorney not being included in the discharge document and requested that clarity on page five around the nurse or doctor role for discharging be resolved. **QS22/118.5** It was agreed that any further points be raised with the Executive Director of Integrated Clinical Delivery/Deputy Chief Executive by the end of the day and that the SOP would be recirculated for approval and implemented by August if possible. It was noted that once the SOP was in place the NU01 would be archived. **QS22/118.6 It was resolved** that any further points be raised by the end of the day and that the amended SOP would be recirculated for approval with implementation being sought as soon as possible.	ALL
QS22/119 Medical Devices Training Policy **QS22/119.1** The Acting Executive Director Of Therapies & Health Science presented the policy highlighting that there was a long standing risk around the ability to provide assurance on training for medical devices as there was not a system in place, but an ongoing live discussion on the subject was happening. **QS22/119.2** An Independent Member queried how colleagues would know if a device was red, amber or green. The Deputy Director Medical Physics clarified that there was no colour coding on devices and the policy sets out that line managers are responsible for training their staff. It was noted that there is a RAG list, which should be included as part of staff induction. The Committee noted that an area of risk would be around agency and locum staff, but additional features had been included in the new policy to clarify arrangements for these staff. **QS22/119.3** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive advised that in her experience devices had been visually identifiable and Acting Executive Director Of Therapies & Health Science and the Deputy Director Medical Physics agreed to explore these options **QS22/119.4** It was agreed that the Deputy Director Medical Physics and Executive Director of Workforce and Organisational Development would look at the triangulation with HSE findings and the policy outside of the meeting. **QS22/119.5** An Independent Member raised a query around mandatory training. It was agreed that the Executive Director of Workforce and Organisational Development would produce an assurance report on Mandatory Training and that this would go to PPPH Committee first and then be circulated to QSE attendees.	GE/PH SG/PH SG

QS22/119.6 Attendees discussed the risk around agency and temporary staff and it was agreed that this would be reviewed and reflected in the policy. It was agreed that the policy would be refined and re-circulated to the Committee and a Chair's Action taken to sign it off. **QS22/119.7 It was resolved** that the Committees discussions be reflected upon and an amended policy circulated to be approved by Chair's Action.	GE
QS22/120 Mental Health Improvement Plan **QS22/120.1** Executive Director of Public Health advised that she would present the detailed plan to the Chair and Independent member on Friday but that good progress was being made. **QS22/120.2** An Independent Member advised that there was an element of receiving the same information as was highlighted in 2018, he raised concerns that there was no confidence that the was any movement and that significant down turn in the service was evident. It was noted that patients and carers needed to be referenced and valued. It was noted that some of the recommendations should be normal practice and not be required in an action plan, concern was raised that actions do not have timelines against them and therefore progress is not being made at speed. **QS22/120.3** The Executive Director of Public Health advised that there was a different approach being taken to ensure some of the basics are right, that patients and carers had been at the heart of the plan and that the plan had been produced to capture six themes that are outstanding and highlight the way forward. It was noted that there were over 100 vacancies within the service and that the recruitment into these posts would see the pace of delivery improve. **QS22/120.4** The Interim Director Of Nursing Mental Health advised that resource would always be the issue as would the environment but the detail would be the changing factor. **QS22/120.5** The Chair enquired as to why the detailed improvement plan had not been provided as requested in March and May and for the July meeting, she clarified that she had not asked for a presentation on the Betsi approach again but the full improvement plan to ensure that the Committee received the detail to be able to give the Board assurance. **QS22/120.6** The Executive Director of Public Health clarified that she had presented what the Executives had felt was appropriate. The Chair advised that if a Committee Chair asks for a specific report or plan it was not the role of the Executive Team to change what is presented at the Committee without the agreement of the Chair. The Interim Board Secretary agreed to give this feedback to the Executive Team. **QS22/120.7** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive advised that reflected on the previous discussion around the HASCAS	MM

work and invited an Independent Member to be involved in those discussions should they wish. **QS22/120.8 It was agreed** that a meeting would be convened between the Committee Chair and the Independent Member lead to review the detailed action plan on Friday and subject to the outcome of that meeting it may be that the matter is referred to the Board. **QS22/120.9 It was resolved** that the Committee took no assurance from the document presented and requested a further feedback session on the detailed plan.	TO
QS22/121 Corporate Risk Strategy **QS22/121.1** The Interim Board Secretary presented the Corporate Risk Strategy highlighting that it was presented at the Audit Committee and that following feedback a meeting had been held with an Independent Member to assess any changes that may be required, these had been incorporated and were highlighted to the Committee via presentation. **QS22/121.2** An Independent Member fed back that it was a much easier document to read and understand. The Interim Board Secretary agreed to review Executive Director titles. **QS22/121.3** The Committee endorsed the Strategy and accepted the recommendation that the Risk Management Group formally report into QSE in the future. **QS22/121. It was resolved** that the Committee noted and endorse the objectives of the risk management strategy and noted and endorsed the Risk Management Strategy for Board approval in July 2022. [Amanda Lonsdale joined the meeting]	MM
QS22/122 Quality & Performance Report **QS22/122.1** The Chair welcomed the Director Of Performance to the meeting and invited questions from members. An Independent Member said that it was disappointing to see the CAMHS figures deteriorating. The Executive Director for Public Health advised that in the adult area mental health demand is running high and is likely to get worse. It was noted that the implementation of the new operating model was having an impact on CAMHS. The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive offered to discuss this further with the Independent Member the following day while they visit YGC. **QS22/122.2** The Chair was disappointed with the deterioration in access to psychological therapies and queried if the service was on target to address that in quarter two. The Executive Director of Public Health agreed to produce a briefing note for the Committee.	TO

QS22/122.3 The Chair raised concerns around sepsis performance. The Executive Medical Director advised that he was concerned about day to day management and that in parallel a discussion around implementation was taking place in clinical audit to identify the issues. **QS22/122.4** The Director Of Performance advised that positively the area of childhood immunisation was on track. The Chair noted that she had heard of concerns around the flu vaccinations not being given at the same times as the Covid ones this year and the impact that may have on the ability to deliver the vaccination programme in primary care. The Executive Director of Public Health advised that JCVI guidance was being followed and discussions were on going with regards to dual vaccinations. **QS22/122.5** An Independent Member highlighted that the paper advises that there were no Never Events in April and May and asked for clarity around this area. The Acting Associate Director of Quality Assurance confirmed that this was correct but that one had been identified after publication of the report. **QS22/122.6** The Acting Board Secretary and Executive Medical Director agreed to pick up a discussion around mortality and benchmarking. **QS22/122.7 It was resolved that** the Committee scrutinised the report noting that there was nothing to escalate to Board.	MM/NL
QS22/123 Patient Safety Report **QS22/123.1** The Associate Director of Quality Assurance presented the Patient Safety Report, noting that he would review page 10 on rapid review and the specific gap identified. A discussion took place around documentation being completed or not such as a falls assessment not being the reason why these incidents occur and therefore to adequately respond to the recurring theme, a more robust action needs to be identified. **QS22/123.2** Acting Executive Director for Nursing and Midwifery advised that the report was a first step and a look back but what was needed would be the improvement work to include KPI's to identify cause and how they will be addressed to ensure it doesn't happen again. **QS22/123.3** The Chair queried the reference to the incident involving the spinal anaesthetic and the Associate Director of Quality Assurance advised that there was a lack of clarity both from the Royal College as well as the Health Board at this point in time. **QS22/123.4** The Executive Director of Workforce and Organisational Development advised that in an accountability review meeting one of the discussions that took place was on mitigated actions and that unless these are able to be put in place and maintained they should not be identified. **QS22/123.5** It was agreed that the Executive Director Transformation, Strategic Planning and Commissioning and the Associate Director of Quality Assurance	

discuss outside of the meeting the details around the consultant who had felt vulnerable with regards to the absence of a check list given that they may well be in the perfect position to lead an improvement piece of work. **QS22/123.6** The Committee discussed the delay in completing investigations in a timely manner, noting that support in this area needs to be given at induction. **QS22/123.7** The Associate Director of Quality Assurance clarified Surgical Safety meant what is nationally reportable and that Never Events are reported elsewhere. He shared the process around rapid learning panels noting that actions are identified following a rapid learning panel/review on Datix, when a completed investigation report is received the early learning is supported by evidence. The work is being taken forward in the round with the Clinical Effectiveness Team to align to the clinical audit plan. **QS22/123.8** Attendees discussed the commissioned Aqua Training emphasising that the training needs to be completed as soon as possible to address the culture issues identified. The Associate Director of Quality Assurance advised that the dates were confirmed for all three cohorts. Discussion around a coordinated training approach took place. **QS22/123.9** The Chair raised a question around the reporting of Ombudsman's cases and it was agreed to pick up outside the meeting the Patient and Carers report. **QS22/123.10 It was resolved** that the Committee received the report	MJ
QS22/124 Quality/Safety Awards and Achievements **QS22/124.1** The Quality/Safety Awards and Achievements paper was received with thanks. **QS22/124.2 It was resolved** that the Committee noted the report.	
QS22/125 YGC Improvement Plan **QS22/125.1** The Chair advised that a cabinet meeting had been convened to talk about the YGC Improvement Plan noting that the Health Board Chair had been very specific about what he expected to see at that meeting. It was noted that a lot of information was received at the meeting on 26 May 2022 in terms of the approach to the development of the plan. **QS22/125.2** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive clarified that there was a dynamic plan that means that the actions from the Hospital Management Team are uploaded into the Improvement plan concentrating on the actions that were identified in the HIW report and the Vascular report around immediate improvement while at the same time applying a governance structure to support TI. The Committee were informed that weekly meetings were taking place with the Hospital Management Team to receive evidence focussing on assurance that there is evidence to support that services	

are safe. It was noted that there is a communication piece of work ongoing. **QS22/125.3** Attendees discussed governance noting that the HIW report had been received at the private QSE meeting on 26 May session and that Cabinet has been set up to review progress to strengthen the level of scrutiny. **QS22/125.4** The Chair noted that she had still yet to see the detail on the YGC Improvement Plan but that she was hoping to see it at the Cabinet meeting. **QS22/125.4 It was resolved that** The committee endorsed the approach being undertaken, the structure of the plan which was based upon thematic and temporal triangulation and includes key outcome measures and noted the progress to date in developing the plan and that the detailed plan would be received at Cabinet.	
QS22/126 Urology **QS22/126.1** The Executive Director of Integrated Clinical Delivery/Deputy Chief Executive apologised to the Committee for there not being a written paper. She highlighted that a multidisciplinary workshop was scheduled for two days' time and that at the meeting the priorities would be agreed with clinicians. The Committee were updated on the recruitment of the network lead. **QS22/126.2** The Committee noted that there was further progress with the robot and that conversations were ongoing with the manufacturers to ensure that the skills of the theatre team were honed to enable them to utilise the robot both post and pre operatively. It was noted that it would first be used in gynaecology as work is undertaken to upskill the urology surgical team. Once this team were competent the colorectal team would be brought in and there would be joint clinical ownership to ensure that the pace is picked up.	
QS22/127 Human Tissue Authority Preparedness Report **QS22/127.1** The Executive Medical Director advised that he had withdrawn the item as the paper was not of the quality required to be received at QSE. It was noted that the inspection would take place in the coming week and that feedback would be received on 18 July 2022. The Chair requested that the QSE receive a briefing before the next meeting given the concerns around safety, best practice and the lack of Human Tissue Reportable Incidents.	NL
QS22/128 Vascular Update **QS22/128.1** The Executive Medical Director recognised the ongoing issues with the Vascular services. It was noted that the same improvement methodology is being brought into the existing vascular improvement plan. Feedback from the Vascular Quality Panel is being received and identifying new concerns with the service mainly around post operative care. It was noted that the Clinical Lead appointment did not happen and that the concern remains that there will not be any applicants for the post and that this would leave a key risk around vascular leadership.	

QS22/128.2 The Chair enquired as to what would happen if there were no suitable applicants and the Executive Medical Director concluded that a mitigating paper was being presented at the Executive meeting the following day on the subject. **QS22/128.3** Attendees discussed the failure to proceed with the appointment, it was agreed that the detail be shared with the Committee on why appointment had not happened. The Chair advised that the work being undertaken outside of the meeting needed to ensure that it is not person dependant. **QS22/128.4 It was resolved that** the received the update from the Vascular Steering Group.	NL
QS22/129 Chair's Assurance Reports from Strategic and Tactical Delivery Groups **QS22/129.1** The Reports were received as a consent item noting that if attendees had any queries, these should be raised outside of the meeting.	
QS22/130 Issues Discussed in Previous Private Session **QS22/130.1** It was noted that at the 26 May QSE the Committee had received updates on the HIW reports and action plans.	
QS22/131 Date of next meeting **QS22/131.1** 6 September 2022	

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

				3/5/22 This should be in a position to complete in time for the next committee.	
	6th July 2021				
2	~~K Williams~~ S Hill	**QS21/97.4 QPR** The Chair also referred to a narrative comment about GP consultation performance but noted that no data had been provided. The Acting Head of Performance agreed to look at this	August	31.8.21 the separate COVID reports routinely include information on GP consultations. 7.9.21 L Reid did not feel the update above answered the original point which was that the QaPR included a narrative comment about GP consultation performance but did not include actual data. She felt this reduced the integrity of the report. This to be fed back to the Acting Director of Performance. 2.11.21 S Hill to follow up and ensure this action can be closed off. 05.01.22 The Performance team will include actual GP consultation activity in the next report. 05.03.22 To remain open as it is being tested by other Committees first.	September
	1 March 2022				
3	M Joyes	An update on all previous Regulation 28's return to the Committee. Review historical R28's	September	Interim position included in the patient safety report. This will be picked up as part of the clinical audit plan and test outcomes	
4	T Owen	**QS22/53 External Serious Incident Reviews MHLD** The Executive Director of Public Health to bring back some		Briefing circulated 25/8/22. Suggest close	

		information on the co-occurring approach.			
	3 May 2022				
5	G Thomason	**QS22/75 Patient, Carer or Staff Story** The Acting Executive Director for Nursing and Midwifery to invite the Dementia Lead to a future meeting which would also help the Board to be reminded about their own dementia responsibilities.		An appropriate date is being sought – potentially 1/12/22 Board Workshop	
6	G Thomason/ M Marcu	**QS22/84 Dementia Hospital Charter** Dementia Nurses to return to a Board Workshop specifically for Board Training.		An appropriate date is being sought – potentially 1/12/22 Board Workshop	
7	N Lyons	**QS22/88 Vascular Services** The Executive Medical Director to share the number of Vascular concerns that had been received and what other ways concerns had been received following the help line.		Shared on with the committee on 7/7/22 in the form of the Patient Safety & Experience Information Report for the Vascular Steering Group	
	6 July 2022				
8	G Evans	**QS22/114 Matters Arising and Table of Actions**	Nov 2022	25.08.22 Delayed due to unforeseen absence in senior Psychology service leadership to complete this work. Children's services	

		The Acting Executive Director Of Therapies & Health Science to reconcile between the outcomes of the actions against the original report had not been concluded.		(Matrics Plant) mapping to be presented to Nov 22 QSE.	
9	M Joyes	**QS22/115 Patient Story** A report on themes and action plans would be created to understand the circumstances around experiences shared.		This report will be shared annually.	
10	S Green	**QS22/116 Report of the Lead Executive** Give support to Managers who are giving statements in good faith and jointly plan work with the Health and Safety Executive (HSE) as the regulator would jointly work with both the Coroner's Office and the HSE.		Update 26.8.22 The action regarding supporting staff who are providing statements as part of investigations is included in the wider work in relation to Just culture and Incident reviews and investigations. Suggest that this specific action is closed.	
11	G Harris	**QS22/118 Discharge Standard Operating Procedure** Any further points be raised by the end of the day 6/7/22 and that the amended SOP be recirculated for approval with implementation being sought as soon as possible.		SOP has gone live. Suggest close.	
12	G Evans	**QS22/119 Medical Devices Training Policy**		26/08/22 Update	

		Acting Executive Director Of Therapies & Health Science and the Deputy Director Medical Physics agreed to explore devices being visually identifiable		An exploratory consultation with colleagues elsewhere in Wales took place in July 22. The overall summary of feedback around the idea is that there are limited benefits in relation to the level of risk reduction that will be achieved: 1. Labels tend to be ignored even when visually identifiable 2. Implementing all existing devices already in use would be a big project – significant time and resources required for very limited gain in risk reduction. Suggest action is closed on the basis that it does not fundamentally affect the Training Policy but further consideration of the wider question about identification of high risk devices be considered by the Medical Devices Oversight Group	
13	S Green	**QS22/119.4** It was agreed that the Deputy Director Medical Physics and Executive Director of Workforce and Organisational Development would look at the triangulation with HSE findings and the policy outside of the meeting.		Update 26.8.22 – The Health and Safety Team are working closely with the Deputy Director Medical Physics to take forward the actions identified in the reviews undertaken. Suggest that this specific action is closed.	
14	S Green	**QS22/119.5** The Executive Director of Workforce and Organisational Development to	November	Update 26.8.22 – Assurance Report is to be submitted to PPPH in November 2022	

		produce an assurance report on Mandatory Training and that this would go to PPPH Committee first and then be circulated to QSE attendees.			
15	G Evans	**QS22/119.6** The policy on training agency and temporary staff to be reviewed, and the Medical Devices Training Policy refined and re-circulated to the Committee and a Chair's Action taken to sign it off.		Policy circulated 26 August 2022 via Chair's Action.	
16	M Marcu	**QS22/120 Mental Health Improvement Plan** The Interim Board Secretary to give feedback to the Executive Team that they should not change the ask of Committee papers without approval of the Committee Chair		Feedback given Suggest close	
17	M Marcu	**QS22/121** Corporate Risk Strategy The Interim Board Secretary to review Executive Director titles in the CRR.		Titles reviewed and amended Suggest close	
18	T Owen	**QS22/122** Quality & Performance Report		Briefing shared 25/8/22 Suggest close	

		The Executive Director of Public Health agreed to produce a briefing note for the Committee on the deterioration in access to psychological therapies.			
19	N Lyons	**QS22/122.6** The Acting Board Secretary and Executive Medical Director agreed to pick up a discussion around mortality and benchmarking.		Mortality Review on the QSE agenda and further work planned on benchmarking and triangulating Suggest close	
20	M Joyes	**QS22/123 Patient Safety Report** Pick up outside the meeting the in Patient and Carers report the reporting of Ombudsman's cases.		Picked up outside the meeting to be included in the next Patient and Carers Report. Suggest close	
21	N Lyons	**QS22/127 Human Tissue Authority Preparedness Report** A briefing before the next meeting be shared on HTA given the concerns around safety, best practice and the lack of Human Tissue Reportable Incidents.		The verbal feedback from the inspection has been received and a report will be produced for QSE following receipt of the final written report.	
22	N Lyons	**QS22/128 Vascular Update** The detail on the failure to proceed with the clinical appointment be shared with the Committee on why appointment had not happened.		This is being picked up by the Executive Director of Workforce and Organisational Development.	

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

Report title:	Patient Story			
Report to:	QSE Committee			
Date of Meeting:	Tuesday, 06 September 2022			
Executive Summary:	The patient story brings the voice of the patient into the meeting. The digital patient story will be played at the meeting. A short summary is included in the attached paper.			
Recommendations:	The Committee is asked to receive and reflect upon the patient story.			
Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery			
Report Author:	Matthew Joyes, Associate Director of Quality Rachel Wright, Patient and Carer Experience Lead Manager			
Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☐	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
In line with best practice, the patient story is presented to the Committee in order to bring the voice of the patient directly into the meeting; it is not presented as an assurance item. However, the accompanying paper describes some of the learning and actions undertaken in response to the story.

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

Next Steps: N/A

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

Betsi Cadwaladr University Health Board
Long COVID Service – Co-Production

A video story told by staff from the Long COVID Service and patient representatives will be played at the meeting.

Overview of Patient Story

The Health Board establish a Long-COVID Recovery Programme in response to people who are experiencing Long Covid symptoms. The Health Board wanted this work to be in collaboration with regional partners and patients.

The following objectives were defined for the initial 18 months of the programme:

- To work with stakeholders to co-design community pathways as required supporting the local population to manage the long-term health conditions resulting from Long-COVID and to improve their outcomes.
- To develop and evaluate value-based outcome measures, working with partners to improve knowledge base around recovery.
- To deliver sustainable service improvements for similar longer-term post-viral conditions e.g. chronic fatigue.

From the outset, the Health Board adopted a strong principal of co-design working closely with patients, stakeholders and clinical practitioners to design a pathway that meets the needs and expectations of people experiencing Long COVID.

Some patients expressed an interest in becoming Long COVID Lived Experience Representatives and joined a partnership group to ensure the voice of the patient is heard throughout the development of this new service, building a true approach of co-production.

Summary of Learning and Improvement

Lived Experience Representatives are committed in their engagement of this service; however now the clinical pathway has been established the partnership group requires a change in direction with the focus now on capturing patient experience feedback such as patient related experience measures (PREM) and patient related outcome measures (PROM) to ensure the service continues to meet the needs of patients.

Staff, stakeholders and Lived Experience Representatives are working with *What Works Wellbeing* to co-develop an Outcome Star PROM for long-term health conditions. There is currently no PROM developed around managing long-term health conditions available in the

UK. This will be an evidence-based tool that can be used by other NHS organisations across Wales and England. BCUHB will be leading the way in developing this outcome measure.

To support the service they are currently recruiting for a Long COVID Patient Engagement Officer whose role will ensure patients' voices are heard, and for ongoing patient and carer feedback to help inform service improvements.

Having Lived Experience Representatives involved in shaping and reviewing services is now a recognised model of good practise across BCUHB and is to be replicated across other services. This is a fundamental cornerstone of the developing Quality Strategy to be presented later in the year, and a key strand of the Targeted Intervention Programme.

The Patient and Carer Experience Team have funding to train 24 staff in co-production 'train the trainer model' from the *Co-production and Involvement Network for Wales* that will be rolled out to staff later on this year. This will further enhance the skills and capabilities of the team in supporting future patient and carer experience improvements.

BCUHB have been shortlisted as a finalist for the Patient Experience Network National Awards (PENNA) for Partnership Working to Improve Experience and the NHS Wales Awards for the recognition of this co-production model in shaping the Long COVID Service.

The Patient and Carer Experience Team will share this feedback across Health Board departments.

The Patient and Carer Experience Team extend their gratitude and appreciation to all staff and patients involved in sharing their story.

Report title:	Executive Lead for Quality – Briefing Paper			
Report to:	QSE Committee			
Date of Meeting:	Tuesday, 06 September 2022			
Executive Summary:	This paper provides the Committee with the Executive Lead for Quality Briefing Paper			
Recommendations:	The committee is asked to receive this report			
Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery			
Report Author:	Matthew Joyes, Associate Director of Quality			
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
The information presented in this report is underpinned by the detailed reports to the Committee.

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

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

Lead Executive Report to the QSE Committee June-July 2022

This paper offers a summary of key quality information for the preceding period between meetings. Detailed information is contained within the reports presented to the Committee.

The Committee is advised this report is live to the point of finalisation and therefore may present more detailed information than that within reports that cover a set reporting period.

New Executive Director of Nursing and Midwifery

The Executive Director of Nursing and Midwifery holds the lead role for quality.

Angela Wood has taken up the role of Executive Director of Nursing and Midwifery at Betsi Cadwaladr University Health Board from 01 August 2022. Angela was previously Director of Nursing, Quality and Leadership at NHS England and NHS Improvement for the North East and Yorkshire. Angela has an extensive background in nursing, leadership, and management and has also held roles at Rotherham Hospital NHS Foundation Trust and Northern Lincolnshire and Goole NHS Foundation Trust. Prior to this, she was Deputy Director of Nursing at the Walton Centre NHS Foundation Trust between 2013 and 2017.

Patient Safety Incidents

In brief, during June and July 2022, 24 nationally reportable incidents were reported to the Delivery Unit. Identifying falls and pressure ulcers remaining the highest prevalence harms. Improvement projects and groups are in place for both areas. Within the period, one new Never Event was reported. No Regulation 28 Notices were received.

The Patient Safety Report provides further detail of patient safety incidents.

Complaints

At the end of July 2022, performance remained below the All Wales target of 75% of complaints closed within 30 working days. On average, the number of complaints closed within the timeframe was 36%. To support reduction in the delayed responses, supportfrom the Corporate Complaints Team has commenced with services to expedite responses and improve performance to meet Welsh Government Key Performance Indicators.
A review of complaint compliance and improvement trajectories will be a focus alongside incident management at future Accountability meetings with the Integrated Health Communities and Divisions.

No Public Interest Reports were received by the Ombudsman, although one draft report has been received in August 2022.

The Patient and Carer Experience Report provides further detail of complaints.

Ysbyty Glan Clwyd – HIW Inspection of the ED

Healthcare Inspectorate Wales (HIW) published their report into the second inspection at YGC ED on 08 August 2022. Gaynor Thomasson has started her new role as Improvement Director for Clinical Safety and is providing on-site support and direction to the team to deliver the improvements. A position update on the improvement plans developed in response to the two inspections is presented to the Committee in the HIW update paper.

National Nosocomial COVID Programme

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

A new programme group has been established in the Health Board to oversee this work, to be chaired by the Executive Director of Nursing and Midwifery as the Senior Responsible Officer. A self-assessment process is currently underway, assessing against the national framework, with support of the NHS Wales Delivery Unit. All NHS organisations are undertaking this ahead of the national programme board in September 2022.

Quality Recognition

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

However, a particular area to celebrate is notification that the Health Board has been shortlisted as a finalist for the Patient Experience Network National Awards (PENNA) and the NHS Wales Awards for the recognition of its work on co-production in shaping the Long COVID Service.

Report title:	**Quality Aspects of the Annual Plan / Integrated Medium Term Plan**			
Report to:	Quality Safety Experience Committee			
Date of Meeting:	Tuesday, 06 September 2022			
Executive Summary:	The purpose of this paper is to update the Committee on the approach to delivering quality aspects within the Annual Plan and development of the next iteration of the Integrated Medium Term Plan (IMTP) submission.			
Recommendations:	The Committee is asked to receive the report and note the areas requiring further development and assurance.			
Executive Lead:	Dr Chris Stockport, Executive Director of Transformation, Strategic Planning And Commissioning			
Report Author:	Sally Baxter, Assistant Director – Health Strategy Matthew Joyes, Acting Associate Director of Quality			
Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
Recently received feedback from Welsh Government highlighted amongst other aspects the need to strengthen the overall quality narrative within the next iteration of the IMTP submission for 2023 - 2026. The submission will include a stronger clear narrative about delivery of quality and specific high risk areas. In addition to the regular performance reporting to the Health Board on the Annual Plan, quality aspects will also be monitored through the Integrated Quality, Planning and Delivery meetings with Welsh Government.				
Link to Strategic Objective(s):	The Annual Plan and IMTP submission set out the Heath Board's response to the national strategic objectives including A Healthier Wales and Ministerial Priorities, as well as addressing local needs and addressing our strategic goals as described in **Living Healthier, Staying Well.**			
Regulatory and legal implications	The development of an approvable IMTP is a statutory duty in line with the NHS (Wales) Act 2006, as amended by the NHS Finance (Wales) Act 2014. The delivery of robust plans is also a requirement under the Targeted Improvement framework.			
In accordance with WP7 has an EqIA been	Yes. An EqIA was produced for the 2022 -			

identified as necessary and undertaken?	2025 Plan.
In accordance with WP68 has an SEIA identified as necessary been undertaken?	Yes. A SEIA was produced for the 2022 - 2025 Integrated Medium Term Plan.
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	All schemes within the current Annual Plan have been required to identify key risks and take action to mitigate against these.
Financial implications as a result of implementing the recommendations	No specific financial requirements arising from this paper.
Workforce implications as a result of implementing the recommendations	No specific workforce implications arising from this paper.
Feedback, response, and follow up summary following consultation	Not applicable
Links to BAF risks: (or links to the Corporate Risk Register)	Not applicable
Reason for submission of report to confidential board (where relevant)	Not applicable

Next Steps:

Implementation of recommendations

- Ongoing monitoring of progress and reporting quarterly in accordance with requirements
- Work collaboratively with the Quality Team to strengthen the overall approach to the Quality narrative within the next iteration of the IMTP submission

List of Appendices:

Appendix 1: Annual Plan schemes addressing quality aspects

MEETING IN PUBLIC
Tuesday 6th September

Quality Aspects of the Annual Plan / Integrated Medium Term Plan

1. Introduction/Background

The Health Board has a duty to develop a three year Integrated Medium Term Plan, financially balanced, which fulfils the requirements of the NHS Wales Planning Framework. As has been reported through the Health Board, the IMTP submission for 2022 – 2025 did not pass the threshold for approval and the Health Board must therefore deliver the first year of this submission as an Annual Plan.

The national Quality and Safety Framework is one of the key strategic documents that sets the context for the IMTP / Annual Plan and includes a focus on quality assurance, the development of pathways to support local improvement and address variation in care, together with value based healthcare.

In March 2022 an initial report was presented to the QSE Committee on quality aspects of the developing IMTP submission. This identified a number of schemes which addressed quality aspects within the draft plan and reflect the key themes of the Quality and Safety Framework as set out above. For completeness, these schemes are included as Appendix 1.

2. Body of report

The confirmation of the Living Healthier, Staying Well goals earlier in 2022 sets the context for the delivery of the Annual Plan and IMTP submission:

- Work in partnership to support people – individuals, families, carers, communities – to achieve their own well-being
- Improve physical, emotional and mental health and well-being for all
- Target our resources to people who have the greatest needs and reduce inequalities
- Support children to have the best start in life
- Improve the safety and quality of all services
- Respect people and their dignity
- Listen to people and learn from their experiences

The final three goals, in particular, are facilitated by the Quality agenda of the Health Board and support the national Quality and Safety Framework and the principles of the Health and Social Care (Quality and Engagement) (Wales) Act.

Further work is being undertaken to link delivery of the Annual Plan and the development of the next iteration of the IMTP submission more closely with the quality agenda. The Planning Directorate are linking closely with the development of the Quality Strategy, which will be aligned with the priorities set out in the Annual Plan and our main objectives. The five Planning Principles are aligned with the aims of the draft

Quality Strategy and the provision of excellent care encompasses safety, quality and patient experience.

Feedback from recent engagement on the Clinical Services Strategy which related to quality aspects has also been fed into the Quality Strategy development process.

The development timeline for the Quality Strategy will enable risks, key issues and priorities being identified through the planning process for 2023 – 2026 to inform the final strategy.

In parallel with these developments, initial discussions have commenced to build on quality surveillance mechanisms to identify and escalate areas of concern, and inform quality, improvement and sustainabiltiy plans. Further detail will be provided as this work develops.

Lastly, further feedback from Welsh Government on the IMTP submission for 2022 – 2025 highlighted the need to strengthen aspects of the narrative in the plan through monitoring of delivery this year, and in development of the next IMTP submission for 2023 – 2026. Clinical risks associated with the plan need to be explored further and mitigation actions more clearly articulated, giving greater visibility and thus assurance on how we are addressing specific areas. There is opportunity for aligning with the Quality Strategy on these aspects, and to strengthen the narrative both for in-year reporting and in developing the narrative for 2023 – 2026.

The Committe are asked to accept this brief update, note the work in progress to strengthen collaboration on quality aspects of planning, and provide any feedback to support this approach.

3. Budgetary / Financial Implications

There are no immediate budgetary implications associated with this paper. Any financial impact associated with initiatives will be escalated through the appropriate governance route.

4. Risk Management

There are risks arising from the organisational pressures, which may constrain the capacity of operational and corporate leads to support the delivery of the plan and quality improvement, including the potential impact of further waves of Covid-19.

5. Equality and Diversity Implications

Equality Impact Assessment and SocioEconomic Impact Assessment were undertaken to support the 2022 – 2025 IMTP prior to submission for approval.

Appendix 1

The following tables outline examples of key schemes within the plan (table 1) to illustrate their contribution to the aim of the NHS Wales quality act domains (table 2):

- Improving safety
- Clinical Effectiveness
- Patient experience

Table 1: Example of schemes within our plan and initial outcomes to be achieved

Scheme	Initial outcomes
Eye Care	People receive appropriate access to on-going care and management of their eye condition.
Further development of the Academy	Wider range of professionals able to support patients with complex primary care presentations. Greater awareness outside of north Wales of rich training, academic and employment opportunities in Primary Care in BCU, resulting in an increase in applicants from forward thinking healthcare practitioners
Mental Health Improvement scheme - CAMHS Transition	Providing consistent equity of access to services across North Wales and provide opportunity for peer support and the sharing of best practice, where children, young people, and their families have access to early help and emotional support when they need it the most
Implementation of Audiology pathway	Greater and quicker access to audiology led care for hearing loss and ear wax management, resulting in • increase in positive interventions to manage hearing loss • quicker intervention to manage hearing loss • less unwarranted use of antibiotics less ear perforation, scarring
Health & Safety Statutory Compliance	• Improved staff awareness of health and safety in the workforce • Staff can easily apply health and safety training in their daily working practice • Systems are implemented across the Health Board to ensure staff are safe at work
Video consultations	Reduction in patient time spent travelling, when video consultation provides an acceptable alternative to a face to face consultation.
Home First Bureaus	Increase in the number of people returning to their own home following a hospital admission Increased number of assessments outside of a hospital setting, leading to a more accurate assessment of need and ability, as well as shorter lengths of stay
Improving minimal access surgery in gynaecology and north Wales specialist endometriosis care	Ability to provide more advanced gynaecology treatment, including for endometriosis in north Wales. This means fewer patients will have to travel for specialist treatment.
Suspected cancer pathway improvement	Improved efficiency through the patient journey leading to improved patient experience. Cancer pathways revised and aligned to achieve the national standard. Improved cancer waiting times.

Vascular	Increase capacity through provision of Middle Grade cover
Care Home support	Improved care, assured against an evidence based quality framework, in those care homes in which the QAF has been deployed.

Table 2: Delivering upon the aims of the NHS Wales quality act: Improving safety; Clinical Effectiveness and Patient experience

Ref	Scheme	Safety	Clinical effectiveness	Patient experience
a.2022.6	Eye Care		●	●
a.2022.7	Further development of the Academy		●	●
a.2022.16	Mental Health Improvement scheme - CAMHS Transition and Joint working			●
a.2022.10	Implementation of Audiology pathway			●
a.2022.8	Health & Safety Statutory Compliance	●		
a.2022.40	Video consultations			●
a.2022.9	Home First Bureaus			●
a.2022.11	Improving minimal access surgery in gynaecology and North Wales specialist endometriosis care		●	
a.2022.36	Suspected cancer pathway improvement			●
a.2022.39	Vascular		●	
a.2022.1	Care Home support			●

Report title:	2022/23 Board Assurance Framework			
Report to:	Quality, Safety and Experience Committee			
Date of Meeting:	Tuesday, 06 September 2022			
Executive Summary:	The purpose of this report is to enable the Committee to review and monitor the updated BAF following its adoption at the August Board meeting. This report incorporates an extract of the BAF for the committee to monitor, which is incorporated in sections 1 and 4 under the strategic aims: *Strategic Aim 1: Improve physical, emotional and mental health and well-being for all/ Improve the safety and quality of all services* *Strategic Aim 4:Respect people and their dignity , and learn from their experiences* It is recognised that further work is required to strengthen the controls, assurances and action plans, with some of the BAF risk areas incorporated within the QSE agenda for this meeting. This work is also aligned to the tasks currently being undertaken to strengthen the Corporate risk register, which is incorporated separately on this agenda.			
Recommendations:	The Committee is asked to: • Note and review the BAF risks that fall within the remit of the Quality, Safety and Experience Committee			
Executive Lead:	Board Secretary			
Report Author:	Molly Marcu, Interim Board Secretary			
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
The BAF includes the risks deemed most significant to the delivery of the strategic objectives of the Health Board. Of those risks, some are outside of the risk appetite /and have significant gaps in controls and assurance				
Link to Strategic Objective(s):	ALL			
Regulatory and legal implications	Alignment to regulatory requirements associated with delivery of patient care as well as a safe working environment under the Health and Safety at Work Act			

Y/N i ddangos a yw dyletswydd Cydraddoldeb/ SED yn berthnasol **Y/N to indicate whether the Equality/SED duty is applicable and provide an explanation below**	**Y**
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	(summarise risks here and provide further detail) (crynodeb o'r risgiau a rhagor o fanylion yma)
Financial implications as a result of implementing the recommendations	Risk Management training will be required as part of the process of enhancing the risk maturity of the organisation
Workforce implications as a result of implementing the recommendations	Not applicable
Feedback, response, and follow up summary following consultation	Feedback received from Executive team, QSE Chair and QSE
Links to BAF risks: (or links to the Corporate Risk Register)	All
Reason for submission of report to confidential board (where relevant)	Not applicable Amherthnasol
Next Steps: • The BAF will be subject to a further in-depth review ahead of the next meeting of the committee, taking into account discussions at this meeting and Board feedback	
List of Appendices: 2022/23 Board Assurance Framework Appendix 1	

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022			
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this standing agenda item is to highlight the discussions which took place during the Risk Management Group meeting on the 2nd August 2022 and to note the progress on the management of the Corporate Risk Register and the new escalated risks aligned to the Committee.			
Argymhellion: ***Recommendations:***	The Committee is asked to: Review and discuss the report.			
Arweinydd Gweithredol: ***Executive Lead:***	Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Justine Parry, Assistant Director of Information Governance and Risk			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	See the individual risks for details of the related links to Strategic Objectives.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	It is essential that the Board has robust arrangements in place to assess, capture and			

	mitigate risks, as failure to do so could have legal implications for the Health Board.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	No
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	No
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	See the individual risks for details of the related links to the Board Assurance Framework.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	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.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	Failure to capture, assess and mitigate risks can impact adversely on the workforce.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The Risk Management Group met on the 2nd August 2022 and further updates to the risks have been incorporated. Please see the individual progress notes on each risk.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	See the individual risks for details of the related links to the Board Assurance Framework.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Camau Nesaf: ***Next Steps:*** The Risk Management Group will be meeting on the 4th October 2022, therefore an updated position of the risks will be presented during the Quality, Safety and Experience Committee on the 1st November 2022.
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Quality, Safety and Experience Corporate Risk Register Report. Appendix 2 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score. Appendix 3 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels.

Quality, Safety and Experience Committee
6th September 2022
Corporate Risk Register Report

1. Introduction/Background

1.1 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.

(NB Work is underway to redesign Committee Risk and Board Assurance Framework reports as part of the new, incoming Once for Wales RL Datix Cloud IQ Risk Module developments)

2. Body of report

2.1 The Risk Management Group met on the 2nd August 2022 to review the Corporate Risk Register which included a "deep dive" into the below risks as a tool for driving learning, sharing best practice and enhancing the Health Board's risk management footprint.

- CRR20-05 – Timely Access to Care Homes.
  It was noted that this risk originally related to the pandemic but that the landscape has now changed and the controls no longer meet the description, gaps. The risk is no longer effective in its current form and collaborative work with the risk team, finance, and operational leads is ongoing to split and rewrite as two separate risks, one risk will focus around quality and safety, whilst the second will focus around contracting and commissioning.
- CRR20-06 – Management of Patient Records.

Meetings will be arranged with the risk leads to update the risks in line with the next Risk Management Group meeting scheduled for the 4th October 2022.

2.2 During the initial escalation of CRR22-23 - Inability to deliver safe, timely and effective care it was noted that the risk was focused on the East region, work is ongoing to broaden this risk into a BCU wide risk.

A meeting will be held with the risk lead to update the risk in line with the next Risk Management Group meeting scheduled for the 4th October 2022.

2.3 The following risks have been incorporated onto the Health Board's risk register and following Executive approval work is ongoing to further develop the risk descriptors, mitigating factors and action plans to include the risks onto the Corporate Risk Register.

- CRR22-25 – Risk of failure to provide full vascular services due to lack of available consultant workforce.
- CRR22-26 – Risk of significant patient harm as a consequence of sustainability of the acute vascular service.

- CRR22-27 - Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.
- CRR22-28 – Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.
- CRR22-29 - Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model.
- CRR22-30 - Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns.
- CRR22-31 - Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model.

These risks are currently awaiting Executive approval following further development to the risk descriptors, mitigations and controls and will be incorporated into the next reporting arrangements for Committee on the 1st November 2022.

2.4 The following table highlights the distribution and throughput of risks by Tier currently recorded within Datix, providing a snap shot view across BCUHB. Work continues to support the development of the Once for Wales RL Datix Cloud IQ Risk Module which will include the development of reporting the breadth and categories of risks recorded in a meaningful and consistent way:

Risk Tier (and risk score: NB Consequence x Likelihood = Risk Score)	Total number of live risks on registers	Number of risks held as 'Being Developed' (not yet live)	Number of live risks added in the last 6 months (not via escalation)	Number of risks closed in the last 6 months (not via de-escalation)
Tier 1 (15-25)	27 ↑	0 ⇔	5 ↑	1 ⇔
Tier 2 (9-12)	400 ↑	56 ↓	45 ↓	85 ↓
Tier 3 (1-8)	228 ↓	57 ↓	14 ↓	109 ↓

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper. Resources for maintaining compliance oversight are overseen by the Risk Management Group.

4. Risk Management

4.1 See the full details of individual risks in Appendix 1.

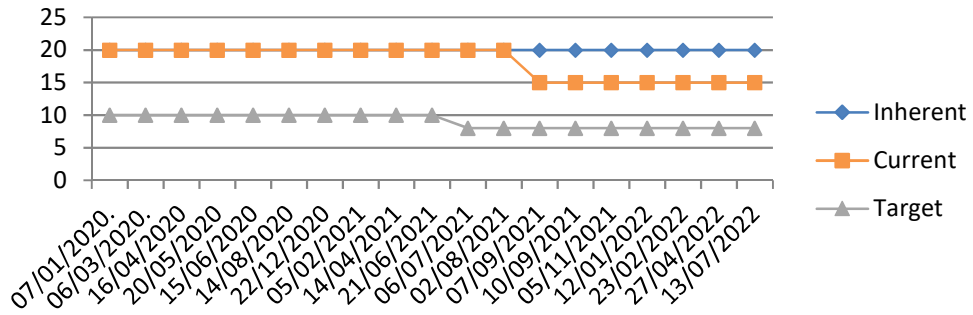
5. Equality and Diversity Implications

5.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

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

Appendix 1 – Quality, Safety and Experience Corporate Risk Register Report

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 13 July 2022
	Risk: Asbestos Management and Control	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 31 March 2023
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, Health and Safety Executive enforcement action including fines, prosecution and reputation damage to BCUHB.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Asbestos Policy in place, with control and oversight at Strategic Occupational Health and Safety Group. 2. Annual programme of re-inspection surveys undertaken. 3. An independent audit of internal asbestos management system completed by an independent UCAS accredited body. 4. Asbestos management plan in place, with control and oversight at Strategic Occupational Health and Safety Group. 5. Asbestos register available. 6. Targeted surveys where capital work is planned or decommissioning work undertaken. 7. An annual training programme for operatives in Estates is in place.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Internal Audit review undertaken against the gap analysis. 5. Self assessment completed and submitted to Welsh Government which use specialist services to review the

8. Air monitoring undertaken in premises where there is limited clarity on asbestos condition. 9. 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. 10. Procurement of specialist asbestos testing and removal services from NHS Shared Business Services Framework. 11. Senior Estates Officer/Asbestos Management appointed to review systems and procedures in line with the Asbestos Management Policy.	returns for consistence and compliance.

Gaps in Controls/mitigations
Not achieving 95% target for compliance with training, it is felt that due to absences 100% compliance is not achievable. Significant progress has been made in terms of training and compliance with further work ongoing, continued to increased compliance is due to long term absences. Current compliance level is 80%. Targeted action through local operations managers will be focused upon to reach 95% and it is anticipated that this will be achieved by quarter one in 2022. Whilst it was anticipated that the 95% compliance rate would have been met by quarter 1, staff shortages due to COVID have been experienced which have influenced the ability to achieve this rate.

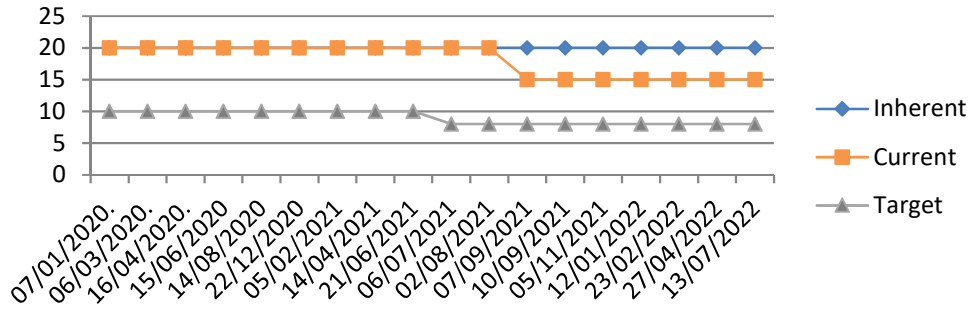
Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current risk position and identification of the newly appointed Senior Estates Officer/Asbestos Management. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Subject to the review by the newly appointed Senior Estates Officer and to no issues of significance identified, it is anticipated that a request to consider a reduction to the current risk score will be made at the next risk submission with consideration also to de-escalate the risk to a Tier 2 following the review. 4. Identification of new Action ID 23728 to implement recommendations following the review by the new Senior Estates Officer/Asbestos Management.

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	31/03/2023	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. This information is currently held by a third party. With the implementation of the MiCad system, this will digitalise the information held locally by the Health Board.	On track
	23728	Implement recommendations following the review by the new Senior Estates Officer/Asbestos Management.	Mr Arwel Hughes, Head of Operational Estates	31/03/2023	Provide assurance that the systems of controls are suitable and sufficient to meet the requirements of Asbestos Management Regulations.	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:** 13 July 2022
	Risk: Contractor Management and Control	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 30 September 2022

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



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Control of Contractors Procedure in place, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 2. Induction process being delivered to new contractors, regularly reviewed and monitored by Head of Operational Estates. Issues of non-compliance are reported to the Head of Service team. 3. Permit to work paper systems in place across the Health Board. 4. Pre-contract meetings in place. 5. Externally appointed Construction, Design and Management Regulations Coordinator (CDMC) in place. 6. Procurement through NHS Shared Services Procurement market test and ensure contractor compliance obligation. 7. Integral evaluation process in place to monitor performance of Health Board contractors with oversight at the Occupational Health and Safety Strategic Group. 8. Approved Contractors Framework for minor works across the Health Board in place, monitored quarterly as part the Contract Performance Review.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

Gaps in Controls/mitigations
Staff resources gap due to demand versus capacity. 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. Reduction and declining of current list of requests and prioritisation of works to align with Health & Safety obligations in terms of the management and control of contractors.

Progress since last submission
1. Controls in place have been reviewed and updated to reflect the current strategic position. 2. Gap in control has been updated to include the mitigation in place. 3. Delay to implement the SHE system has resulted from the supplier's ability to provide the details requested by the Health Board to be able to approve implementation. 4. Action ID 12256 – Action delayed due to further delay to implement the SHE system. 5. Action ID 12258 – Action delayed with finalisation following implementation of the new operating model when roles and responsibilities have been confirmed.

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	12252	Identify service Lead on each site to take responsibility for Contractors and Health & Safety Management within Health & Safety 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	On track

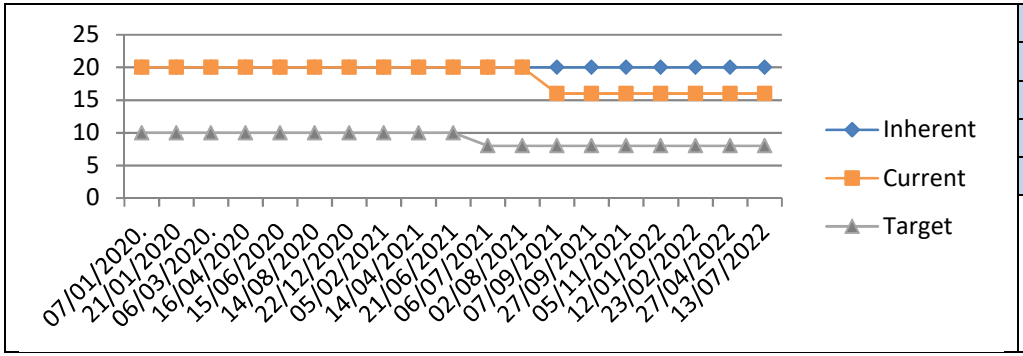
					structure. Service based Health and Safety Team Leaders will be appointed with each of the Operational Estates geographical areas to manage Control of Substances Hazardous to Health (COSHH) and Inspection process to ensure compliance. July 2022 progress update - The action will fall in line with the implementation of the new operating model when roles and responsibilities will be confirmed.	
	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 software.	Mr Rod Taylor, Director of Estates & Facilities	31/01/2022	Implementation of (SHE) - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor appointment criteria across the Health Board. July 2022 progress update - Current robust paper based system is in place. Further delay to implement the SHE system has resulted from the supplier's ability to provide the details requested by the Health Board to be able to approve implementation, anticipated implementation by March 2023.	Delay
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of	30/09/2022	Implementation of the SHE - 'Management of Contractor' software will ensure a robust	On track

			Estates & Facilities		guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor Management Processes.	
	12258	Identify responsible person to review Risk Assessments and signs off the Method Statements (RAMS). Skills, knowledge and understanding required to be competent to assess documents (Pathology, Radiology, IT etc.).	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	Implementation of SHE - 'Management of Contractor' software will ensure a robust guidance and compliance for contractor's appointment criteria across the Health Board. To note – Management of Contractors within the Health Board includes other service areas outside of Estates and Facilities responsibilities e.g. Capital Development, Information Management and Technology and Radiology etc. An additional work stream will be required by these areas to ensure compliance with the Health Board Contractor	Delay

					Management Processes. July 2022 progress update - Finalisation following implementation of the new operating model when roles and responsibilities have been confirmed.	
	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 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 Control of Substances Hazardous to Health and Inspection process to ensure compliance.	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:** 13 July 2022
	Risk: Legionella Management and Control.	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 30 September 2022

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Legionella and Water Safety Policy in place, reported to and signed off by the Water Safety Group, which is reported to Infection Prevention Sub-Group and Quality, Safety and Experience Committee. 2. Risk assessment undertaken by Clearwater, with action and issues reported to the Water Safety Group. 3. High risk engineering work completed in line with Clearwater risk assessment. 4. Bi-Annual risk assessment undertaken by Clearwater. 5. Water samples taken and evaluated for legionella and pseudomonas. 6. Authorising Engineer Water Safety in place who provides annual report. 7. Annual Review of the Health & Safety Self Assessments undertaken by the Corporate Health & Safety Team.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Strategic Infection Prevention Group. 4. Quality, Safety and Patient Experience Committee.

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. 11. Local Infection Prevention Groups in place with oversight of water safety.	

Gaps in Controls/mitigations
1. There is a weakness that little used outlets are not reported to Estates for management and control. For example - ward shower temporarily used as a store, therefore it is not part of Estate flushing programme. Regular topic of the Water Safety Group which has clinical representation and feeds into local Hospital Management Teams. 2. BCUHB wide Water Safety Plan – Plan has been developed, consulted upon and final draft completed. Plan has also had approval from the authorising Welsh Government Appointed Engineer - Water Safety, which will provide the legal requirement under L8 for Processes and Controls for Water Safety Systems. Final version ratified by the Infection Prevention Sub-group in May 2022. 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, which forms part of the ongoing business case. Included in the Integrated Medium Term Plan, supported by risk ID 4283.

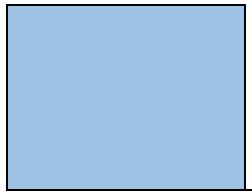
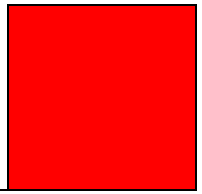
Progress since last submission
1. Controls in place review to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Action ID 12263 – Action closed with the information reported through local Infection Prevention and Control Groups. Process for information collection has been described with the collection of information implemented. 4. Action ID 12264 – Action closed as forms part of the Water Safety Plan, action completed and implemented. 5. Action ID 12268 – Action closed as completed. 6. Action ID 19015 – Action delayed as the business case approved as part of the Integrated Medium Term Plan and awaiting allocation.

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	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. July 2022 progress update - Anticipated delay to the action completion date. Due to the scale of implementation requirements for baseline CAD drawings for all Health Board owned property. The target completion date for the work is end of November 2022. Until this work is complete schematic plans for water safety etc. cannot be uploaded to the MiCAD, the action will not be completed prior to this period.	On track
	12263	Departments to have information on all outlets and	Mr Rod Taylor,	30/06/2022	Action Closed 13/07/2022	Completed

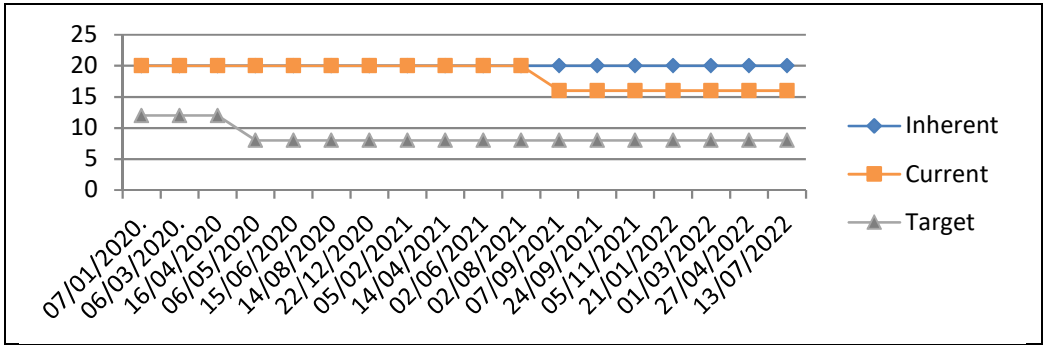
		deadlegs, identification of high risk areas within their services to ensure they can be effectively managed.	Director of Estates & Facilities		All water outlets within managed departments have outlets run as part of the cleaning schedule undertaken by domestic services. Deadlegs are removed on identification and assessment of risk. July 2022 Progress update - Information reported through local Infection Prevention and Control Groups. Process for information collection has been described with the collection of information implemented.	
	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	Action Closed 13/07/2022 This forms part of the Water Safety Plan to ensure water safety compliance. This will be completed and submitted in March 2022 for ratification by Infection Prevention Sub-Group. July 2022 progress update - Action closed as completed and implemented.	Completed
	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). Progress update - Escalation	On track

					process is included in the Water Safety Policy exception reports provided to the Infection Prevention Group from the Water Safety Group.	
	12267	Awareness and training programme in place to ensure all staff aware as part of 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 Standard Operating Procedures and check sheets.	Mr Rod Taylor, Director of Estates & Facilities	30/11/2021	Action Closed 13/07/2022 A policy for Water Safety Management is currently in place – A consultant has been appointed to review current procedural documents for each area with the objective to develop one policy document. As part of the Water Safety Plan infection prevention integrated within key sections of the plan. July 2022 progress update – Action closed as complete.	Completed
	19015	Secure funding and appointment of 3x band 7 Senior Estates Officers for water safety.	Mr Rod Taylor, Director of Estates & Facilities	31/03/2022	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.	Delay

					July 2022 progress - Business case approved as part of the Integrated Medium Term Plan and awaiting allocation.	

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 13 July 2022
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 30 September 2022

There is a risk that the Health Board is non-compliant with Fire Safety Procedures (in line with Regulatory Reform (Fire Safety Order 2005). This is caused by a lack of robust Fire Safety Governance in many service areas /infrastructure (such as compartmentation), a significant back-log of incomplete maintenance risks and lack of relevant operational Risks Assessments. This may lead to a major Fire, breach in Legislation and ultimately prosecution against BCUHB.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Fire Safety Policy established and implemented, annual report submitted to Board and supported by Welsh Government. 2. Fire risk assessments in place. 3. Fire Engineer regularly monitors Fire Safety Systems. 4. Specific Fire Safety Action Plans in place with oversight through the Fire Safety Management Group. 5. Annual Fire Safety Audits undertaken. 6. Escape routes identified and evacuation drills undertaken, established and implemented. 7. Fire Safety Mandatory Training and Awareness sessions regularly delivered to BCUHB Staff. 8. Fire Warden Mandatory Training established and being delivered to Nominated Fire Wardens.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee. 4. Annual Compliance returns submitted to Welsh Government.

9. Appointed Authorising Engineer for Fire Safety in place through NHS shared services (specialist estates services).	

Gaps in Controls/mitigations
1. Insufficient revenue funding to maintain the active and passive fire safety measures within the infrastructure to ensure compliance. Prioritisation of maintenance regimes in place by the use of risk based assessments. 2. Insufficient capital to upgrade active and passive fire safety measures within the infrastructure. Two applications to Welsh Government for Programme Business Cases (PBC) for additional funding to upgrade essential infrastructure measures to ensure compliance with current standards at Ysbyty Gwynedd and Wrexham Maelor hospitals. a) Ysbyty Gwynedd - Programme business case submitted to Welsh Government currently in discussion to secure capital for professional fees to develop a priority list of fire safety measures in advance of the site wide re-development. b) Wrexham Maelor Hospital - £40m allocated to the site which includes fire safety for active and passive fire safety measures.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Action ID 12274 – Action delayed, engagement with the Stronger Together Transition Programme Lead around incorporating into the operating model work plan for the identification of roles and responsibilities for building responsible persons for fire safety.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

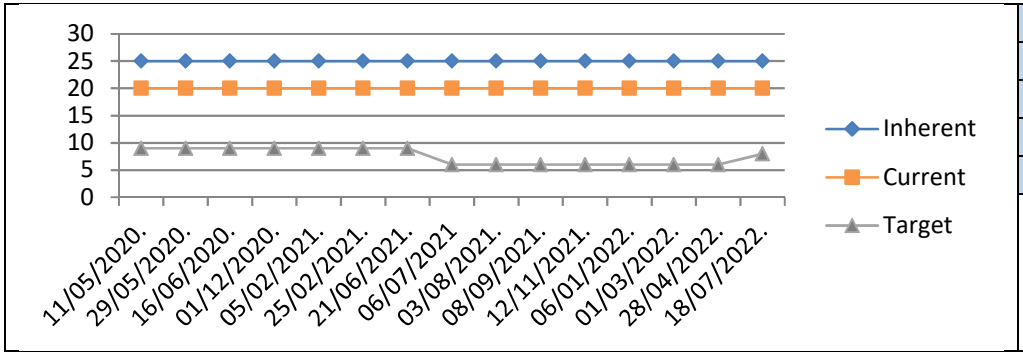
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented	12274	Identify how actions identified in the site Fire Risk Assessments are	Mr Rod Taylor, Director of	31/07/2022	Escalation through Hospital Management Teams, Area Teams and MH&LD management teams	Delay

to achieve target risk score		escalated to senior staff and effectively implemented.	Estates & Facilities		with site responsible persons has been completed. Assurance on implementation of actions outstanding. July 2022 progress update - Engaged with the Stronger Together Transition Programme Lead around incorporating into the operating model work plan for the identification of roles and responsibilities for building responsible persons for fire safety.	
	12276	Consider how bariatric evacuation training is undertaken and define current plans for evacuation and how this is achieved.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	To be included in site specific manual and training developed with Manual Handling Team. July 2022 progress update - Following participation in the all Wales Working Group for bariatric patients, awaiting an all Wales guidance document or inclusion in hospital evacuation plans, anticipated by the end of September 2022.	On track
	15036	Fire Risk Assessments in place Pan BCUHB.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Improve safety and compliance with the Order. July 2022 progress update - Undertaking reviews of fire risk assessments on a prioritised basis to be delivered by the target date.	On track
	21491	Review and refresh existing BCU Fire Safety Strategy.	Mr Rod Taylor,	30/09/2022	Fire Safety Strategy will bring all procedures, action plans etc.	On track

			Director of Estates & Facilities		together to improve governance control and oversight of Fire Safety Management. The Corporate Health & Safety team are undertaking a gap analysis of fire safety management and the outcome of the review is awaited to support the development/review of the strategy. July 2022 progress update - The Fire Safety Policy has been reviewed and updated, the development of the Fire Safety Strategy and supporting documents to support are on track.	

CRR20-05	**Director Lead:** Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 11 May 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 18 July 2022
	Risk: Timely access to care homes	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 30 September 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.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	5	4	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Multi-Agency Oversight Group and Care Provider Operational Group continue to meet to oversee the ongoing Covid response, to support recovery and ensure sustainability of the sector to respond to care home and domiciliary care demand with clear pathways for escalation in place. 2. North Wales care homes single action plan provides the framework for the Multi-Agency response and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB). This group will now review the Health Boards current position against the recommendations of Operation Jasmine. 3. Development of the Quality Assurance Framework - this work is overseen by a Multi-Agency Implementation Group with sign up from the 6 Local Authorities and the RPB. The work is supported by 6 work streams which picks up the ongoing work around Covid and recovery.	1. Oversight via the Care Home Cell which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Oversight by the Regional Commissioning Board who report to the Regional Partnership Board.

4. Continuing Health Care Operations Group in place to ensure the consistent implementation of the new CHC Framework, sharing lessons learnt from retrospective reviews and ombudsman reports. Co-ordination of the contracts including Pre-Placement Agreement and Commissioned Placement Fees is also in place.	

Gaps in Controls/mitigations
1. There is a significant shortage in accessing appropriate placements in care homes with a worrying trend of care home closures and homes de-registering nursing beds. The Market Stability Report has now been published in draft (subject to ratification by the Health Board and 6 Local Authorities by October 2022). Urgent demand and capacity work has commenced as part of the requirement to commission an additional community care placements by October 2022 (243 placements for North Wales). 2. Insufficient domiciliary care provision due to retention and recruitment issues - home first teams providing domiciliary care to support discharge, but insufficient domiciliary care provision to step down to. Urgent demand and capacity work has commenced with anticipated completion by October 2022 in line with the publication of the Market Stability Report and as part of the additional community care placements. 3. Lack of a standardised live system for reporting across North Wales for cause/delay in discharge for medically fit for discharge patients, currently being collected manually. This has been escalated to the Silver Command Operations Resilience Meeting. Work ongoing with IT and Performance to develop digital system. This will ultimately be part of the revised Discharge Policy. Interim solution for providing consistent data implemented in May 2022. 4. No signed Pre Placement Agreement (PPA) - lack of controls in place for addressing concerns, monitoring quality - there is only informal voluntary co-operation. This gap in control is shared with the 6 Local Authorities. There is a joint PPA working group in place but failure to 'sign off' continues. Regional Commissioning Board has sought legal advice. 5. Commissioned Placement Fee Setting - Health Board has agreed to make an interim uplift whilst awaiting national pay awards. 6. Lack of resources to develop has resulted in the development of an integrated Health and Social Care Bank and Memorandum of Understanding to be escalated to the Regional Partnership Board and the Regional Workforce Board.

Progress since last submission
1. Due to the gaps in controls, and the current demands on patient flow, agreement for a review of this risk with the intention of splitting into two. One in relation to contracting and finance, and the second in relation to quality and assurance (including MFFD). 2. Controls in place reviewed and updated to reflect current risk position. 3. Gaps in controls updated to reflect that there is a work programme in place to review the discharge policy which will include a task and finish group to address the gaps in medically fit for discharge with a report providing a standardised approach for North Wales. In addition work progressing with IT looking at a national data set. 4. Assurances updated to reflect current risk position.

5. The Health and Social Care transition plan was updated on 18th July 2022, the extension to the Target risk due date will allow time to interpret and implement the next stages required.
6. Pre-Placement Agreement is in the final stages by the 6 Local Authorities and Care Forum Wales and will be sent out to providers for signing in September. Consideration is being given to the implications of any provider refusing to sign the PPA with the aim of having a joint response plan for the 6 LAs and Health Board.
7. In response to recommendation 2 and 4 of the Welsh Audit Office report on Commissioning Older Person's Care, a workshop is being arranged for September.
Recommendation. 2 - The current approach for commissioning care home places can cause tensions between partners and result in poor value and poor service user experience. North Wales councils and Betsi Cadwaladr University Health Board need to work together to review local arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users, and each other.
Recommendation 4 – North Wales councils and Betsi Cadwaladr University Health Board through the Regional Commissioning Board need to develop a regionally agreed care home commissioning strategy and following this, develop an associated delivery plan.
8. Action ID 18025 – the action remains delayed and is linked to action ID 20074. This was escalated to the Regional Workforce Board in July with the recommendation of appointing some dedicated support.
9. Action ID 20074 - Action remains delayed as meeting not re-established as anticipated by the Regional Partnership Workforce Board, therefore March 2022 target completion date not anticipated, work remains ongoing to progress with plan for this to be established prior to this year's winter pressures, anticipated completion by end of August 2022.
10. Further consideration taken to develop a care provider risk, work is ongoing to develop this risk.

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

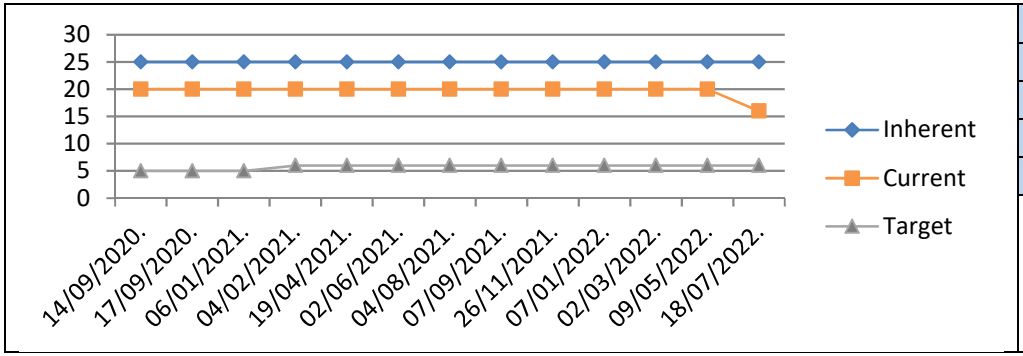
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/04/2022	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge.	Delay

target risk score		package for Independent Providers.			July 2022 progress update - Action delayed. This was escalated to the Regional Workforce Board In July with the recommendation of appointing some dedicated support, this action links to action ID 20074.	
	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. July 2022 progress update - Action remains delayed as meeting not re-established as anticipated by the regional partnership workforce board therefore March 2022 target completion date not anticipated, work remains ongoing to progress with plan for this to be established prior to this year's winter pressures, anticipated completion by end of August 2022.	Delay
	22182	Review and update Health Board Discharge policy.	Ms Jane Trowman, Care Home Programme Lead	30/09/2022	Discharge policy reviewed, updated and will support the assessment around medically fit for discharge patients.	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:** 18 July 2022
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 31 December 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.



	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Decreased		

Controls in place	Assurances
1. Outsourcing process and group in place to review progress against the contract. 2. Cataract outsourcing - All cataracts (internal and outsourced) have been risk stratified in order of visual impairment, to deal with the most clinically pressing cases first. 3. 'Once for North Wales' process is in place, partially across all sites, Cataract patients who are already clinically prioritised may be shared across all three units in North Wales to ensure equity of access. 4. Once for North Wales/mutual aid process allows partial flexibility for cross region movement of Cataract and Intra Vitreal Injection patients and the ability to allocate further	1. Risk is regularly reviewed at local Quality and Safety meetings. 2. Risk reviewed at monthly Eye Care Collaborative Group. 3. Monthly reports to Welsh Government against Key Performance Indicators for eye care measure and Key Quality Indicators.

clinic slots. No longer being utilised. All staff across 3 sites recruited except Consultant hours in East. Go live additionally being progressed. 5. Diabetic Retinopathy Integrated Pathway now in place across all 3 sites. 6. Monthly monitoring of the application of the Cataract Priority Targeting List (PTL) to ensure Pan BCU reduction of access inequity. 7. Optometry Diagnostic Treatment Centres Single Tender Waiver enabled continuation of use of Primary Care Optometry (until September 2022). 8. Clinical condition dashboard now available, beta stage is live and implemented to support documentation and site self-management of clinical condition used to manage services. 9. Pan BCUHB Clinical Lead now appointed.	4. All Wales and Mersey Internal Audit Agency audits have taken place, and reports received to which BCUHB is responding. In addition two clinical condition audits are undertaken annually by Welsh Government. 5. Performance reviewed at Secondary Care Accountability Meetings.

Gaps in Controls/mitigations
1. Further table-top risk stratification is challenged by reduced office based decision making for clinicians as a consequence of their return to expanded clinical activities. Continuing to stratify patients into R1, R2 and R3 to enable prioritisation of those at risk of permanent sight lost. In addition further capacity is planned for Intra Vitreal Therapy (IVT) across all regions as part of the approved business case and additional Central region business case. 2. Outsourcing of the cataract activity is in place along with additional temporary administration support, however, there is need for sustainability moving forward. 3. Current partnership pathways which mitigates waiting times and reduce capacity during Covid-19 are reliant upon an assigned clinical condition. A significant number of patients do not have a clinical condition logged on the system. Standard Operating Procedure has been refreshed and a review is undertaken with a monthly clinical condition report to monitor data quality against clinical condition and sites produce redress action plans. 4. National Standard currently not being met, guidance for number of cataracts being undertaken per list is currently set to 6-8, the Health Board is running at 2.8-3.6, differences in national standards between number of cataract procedures per list. Regional Treatment Centres and Clinical Pathways contract formally with Get it right first time (GIRFT) in ophthalmology to review, design and implement new pathways to deliver high volume low capacity productive theatre sessions. First session took place on the 28th February 2022. GIRFT (Get it right first time) to commence working with Ophthalmology in Autumn 2022.

Progress since last submission

1. Controls in place reviewed and updated to reflect current risk position.
2. Gaps in controls reviewed and updated to reflect current risk position.
3. Proposal to reduce the current risk score from 20 (Consequence 4 x 5 Likelihood) to 16 (Consequence 4 x 4 Likelihood) due to the closure of a number of actions. West have recruited a locum Consultant for 12 months cover and are on target to permanently recruit at the end of the 12 month period. Central have recruited to Consultant post from 01 July 2022. East have not recruited but Pan BCU amalgamation of vacancies to increase to maximise recruitment are being progressed and mutual aid is available to reduce potential inequity of access. Challenge to risk lead to confirm the implementation of the remaining outstanding action will achieve target risk score.
4. Diabetic retinopathy primary Optometry Diagnostic Treatment Centres (ODTC), further funding has been achieved from Welsh Government for 12 months to September 2023.
5. 'Clinical condition data quality improvement': two of the 3 sites are on target for delivery of trajectory improvement target of the 01 September 2022.
6. Cataract Outsource trajectories (400 patient appointments per month) consistently achieved, increasing contract to 600 appointments per month from August 2022, on track to redress over 52 week breaches by close of 2022. Regional Treatment Centre (RTC) has progressed to the design phase with programme on track. GIRFT (Get it right first time) to commence working with Ophthalmology in Autumn 2022.
7. The service is progressing risk planning and review, categorised by clinical condition to reflect national pathway development and prudent eye care strategies to develop more sustainable services.
8. Action ID 20392 – Action remains delayed, with partial recruitment mitigation - all sites recruited to all but Consultant posts. Consultant recruitment potential to be maximised through amalgamating vacancies to progress a Pan BCUHB post.
9. Action ID 20995 – Action closed with 3 additional non-medical injectors have been trained.
10 Action ID 22093 – Action closed as Interim Optometry Advisor recruited and commenced end of June 2022. Substantive post interviews undertaken in June 2022 and successfully recruited against, substantive post holder commences post in September 2022.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways Strengthen our wellbeing focus	BAF21-02 BAF21-04

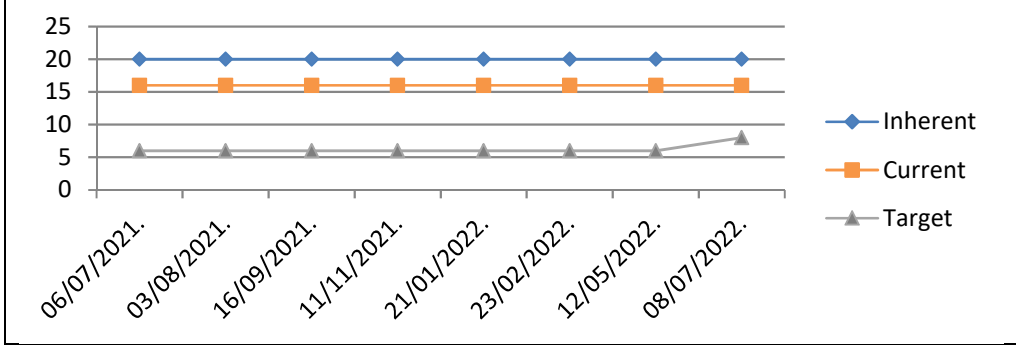
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	20392	Following approval of business case, recruitment of clinical and admin posts for Intra Vitreal Therapy 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. July 2022 progress update - Partial recruitment mitigation- all sites recruited to all but Consultant posts. Consultant recruitment potential to be maximised through amalgamating vacancies to progress a Pan BCUHB post. Sites to submit vacancy update by close of 18.7.22.	Delay
	20995	Training of additional non medic Intra Vitrael Therapy (IVT) injectors.	Mrs Jackie Forsythe, Eye Care Co-ordinator	30/06/2022	Action Closed 18/07/2022 Additional non medic injectors will reduce waiting times for new Intra Vitrael Therapy patients which will reduce the likelihood of the risk materialising. July 2022 progress update - Pan BCU 3 additional non-medical injectors have been trained.	Completed

	22093	Replacement of Optometric advisor.	Alyson Constantine, Site Acute Care Director	30/06/2022	Action Closed 18/07/2022 To support the communication between the Health Board and the Optometrists during the implementation of the National optometry reform contract currently with Welsh Government. July 2022 progress update - Interim Optometry advisor recruited and commence end of June 2022. Substantive post interviews undertaken, June 2022 and successfully recruited against, substantive post holder commences post in September 2022	Completed

CRR21-13	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 07 December 2017
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 08 July 2022
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 30 December 2025

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.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Workforce Recruitment and Retention Strategy in place and actively monitored with initiatives in place to maximise recruitment and retention across the nursing workforce. 2. Nurse Staffing Policies NU28/MHLD 0028 outlines standards and escalation in relation to identifying and mitigating nurse staffing shortfalls across wards and departments. Nurse staffing vacancies and recruitment activity is monitored through the nursing recruitment and retention group which currently reports to the Strategic Workforce Group. 3. Bi-annual Nurse Staffing calculations are undertaken in line with the Nurse Staffing Levels (Wales) Act 2016 for all acute adult medical and surgical inpatient wards, and paediatric	1. Risk CRR21-13 is reviewed and monitored at the respective local Quality and Safety meetings. 2. Compliance with the Nurse Staffing Act and Nurse Staffing calculations are reported to the Board bi-annually (May/November) via the Quality, Safety

inpatient wards (Section 25B). Additionally, and in keeping with the principles of the legislation nurse staffing calculations are also undertaken in other areas of acute services such as admission portals, Emergency Departments and areas of high care. 4. A Strategic Recruitment and Retention Group in place to monitor and develop forward look recruitment and retention initiatives to mitigate nursing shortfall over the next 5 years. 5. Roster Policy WP28A in place and monthly roster KPI reports are issued to the Directors of Nursing to ensure roster performance is actively managed to enable maximum utilisation of nursing workforce across the Health Board. 6. Managing Attendance at Work Policy WP11 in place with sickness, absence and wellbeing pro-actively managed to ensure the nursing workforce is optimised. 7. Utilisation of the SafeCare allocate system to provide a live/real time view of nurse staffing levels, skill mix, and patient demand. The system provides nurse managers with visibility across wards and areas enabling acuity based, safety driven decisions regarding nurse staffing and the deployment of staff. 8. BCUHB Nursing Career Framework in place and utilised to develop and train our existing nursing workforce to meet identified workforce gaps and meet succession plans across the Health Board. 9. Workforce planning and commissioning process in place to triangulate the requirements to develop and deliver the nursing pipeline to meet the current and future needs within the nursing workforce across BCUHB. 10. Full representation and active participation in national policy and decisions making forums such as All Wales Nurse Staffing Group, All Wales Recruitment and Retention Group.	and Experience Committee as the designated committee. 3. Monthly roster KPI reports are issued to identify areas in need of improvement and areas requiring targeted support. 4. Monthly SafeCare compliance reports have been developed to identify areas in need of targeted support to enable a live view of nurse staffing levels, skill mix, and patient demand. 5. Nurse Recruitment and Retention workplan aligned to organisational priorities, CNO principles and key national drivers/strategy. 6. Monthly sickness absence reports produced by WOD, monitored via the workforce utilisation meetings, and managed locally by senior nursing teams.

Gaps in Controls/mitigations
1. There remains some variability in adherence to the Rostering Policy in relation to Key Performance Indicators e.g. Annual Leave/training. A Workforce Nursing Utilisation Dashboard has been developed and introduced to senior nursing teams to optimise nurse staffing rosters. 2. Whilst adult acute medical and surgical, and Area Teams Central and West have fully implemented the Safecare Allocate System, East Area, Paediatrics and Mental Health are yet to implement. Although the Health Board has been using the system for some time there has been a significant change at matron and ward manager level and it is recognised that additional support is required to these areas to re-establish the discipline and compliance required to enable acuity based, safety driven decisions regarding nurse staffing. An implementation plan will oversee the roll out in outstanding areas. The All Wales SafeCare Standard Operating Procedure will further guide and strengthen the use of the system at an operational level. The newly appointed Nurse Staffing Programme Lead will oversee the implementation and associated training requirements relating to the SafeCare System.

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. Plan being developed to move all nurse staff groups onto roster with a specific IT training plan aligned to this initiative.
4. Whilst the recruitment and retention strategy and plan are in place, this needs updating in line with the update of the Health Board's People Strategy. Individual initiatives are in place to inform data analysis and the revised strategy will take these into account along with the wider All Wales recruitment and retention initiatives. This is being led by Director of Nursing for Workforce Staffing and Professional Standards.
5. There remains a gap in filling of nursing vacancies across the Health Board, continued advertising and recruitment and development of business case for the oversees programme and support within the nurse recruitment team.

Progress since last submission

1. Controls in place reviewed to ensure relevance with current risk position.
2. Gaps in controls reviewed and updated to ensure relevance with current risk position.
3. Following previous discussions regarding target risk score trajectories, with the extension of the target risk date to December 2025, it is envisaged a reduction in the current risk score to 12 (4x3) by Dec 2023 will be achievable if the business case for the recruitment of nurses, and the business case for additional resources within the nurse recruitment team and the implementation of the leadership and development programmes are approved.
4. Appointment of the post of Nurse Staffing Programme Lead with the start date of July 2022 will lead on the full implementation of SafeCare.
5. Action ID 15635 – Action delayed due to the new People Operating Model (Workforce) being pulled back, it will be in place by 30/09/2022.
6. Action ID 17433 – Action delayed, as part of the newly implemented People Strategy and Plan, part of the priorities will be a review of education and learning requirements and the development of a leadership development framework. This is a transformational piece of work that sits under the pillar of 'how we improve and transform'. The work to establish a group to develop and co-design the offer will be established within the next few months.
7. Action ID 18834 – Action delayed, proposal of extension of the action due date to 30/09/2022, due to ongoing system pressures and workforce operating model reconfiguration. Plan to go live with the new utilisation dashboard from 1st September and rollout across nursing management throughout September to ensure it is embedded into nursing management decision making going forward.
8. Action ID 22122 – Action delayed, dependant on the people strategy being developed and approved including investment in the oversees nurse programme and nursing team, anticipated completion by December 2022.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Effective alignment of our people (key enabler)	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	This action will assist to appropriately mitigate the potential impact and/or likelihood of this risk were it to materialise. This will increase the ability to expedite recruitment and increase volume. The individual benefits and Key Performance Indicators of the business case are linked to the relevant sections of our corporate risk register. July 2022 progress update – this action is now delayed due to the new People Operating Model (Workforce) being pulled back, it will be in place by 30/09/2022.	Delay
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include	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	Delay

		Ward Managers, Heads of Nursing and subsequently aspirant programmes.			within the Nursing workforce. In 2021/2022 the Health Board embarked on an ambitious three year people and organisational development journey (Mewn undod mae Nerth/Stronger Together). This was and is aimed at enabling the organisation to move forward and deliver its Clinical Strategy/Plan through delivery of its People Strategy and Plan – Stronger Together. The feedback from over 2,000 staff has informed the development of 5 programmes of work, one of which is 'the Best of our Abilities', this includes the development of an integrated Leadership & Management Development Framework for all professional groups, aligned to a new Learning and Education Academy. The risk associated with the development of specific leadership offers related to specific staff groups, i.e. Head of Nursing and Ward Manager programmes will be reviewed as part of this work, with a proposal to develop a new Framework which will be inclusive of all	

					professions and will provide a more streamlined, multi-disciplinary approach. July 2022 progress update - as part of Stronger Together and the feedback from the discovery phase the provision for future leadership programmes will be reviewed to ensure that we have programmes that support leaders across all professions. As part of the newly implemented People Strategy and Plan, part of the priorities will be a review of education and learning requirements and the development of a leadership development framework. This is a transformational piece of work that sits under the pillar of 'how we improve and transform'. The work to establish a group to develop and co-design the offer will be established within the next few months.	
	17509	Exploration of the Welsh equivalent Global Learning Programme.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	The Global Learners Programme offers an exciting 3 year work-based educational opportunity for overseas nurses to work in the NHS.	On track

					This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development. July 2022 - Next national workforce meeting to take place in the Autumn, issue will be raised at the meeting for an update.	
	18834	Introduce targeted monitoring across rosters, through Key Performance Indicators management to reduce agency expenditure and maximise substantive staff usage.	Mr Nick Graham, Workforce Optimisation Advisor	30/06/2022	Effective utilisation of substantive staff. July progress update – Proposal of extension of the action due date to 30/09/2022, due to ongoing system pressures and workforce operating model reconfiguration. Plan to go live with the new utilisation dashboard from 1st September and rollout across nursing management throughout September to ensure it is embedded into nursing management decision making going forward.	Delay
	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, 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

					July 2022 progress update - Action remains on track for December 2022.	
	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.	Jones , Mandy	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. July 2022 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and work is ongoing to implement the programme.	On track
	22121	Implement Allocate Safecare system to all clinical areas and associated training requirements.	Mrs Alison Griffiths, Director of Nursing Workforce	30/09/2022	Ensure that Health Board has increased visibility of the Nursing workforce to ensure efficient utilisation of nursing staff and better identify areas of risk to enable appropriate mitigation at a local level. July 2022 progress update - Appointment of Nurse for safe care will begin in July who will lead on the implementation.	On track
	22122	Refresh and update the Nursing Recruitment and Retention strategy.	Mrs Alison Griffiths, Director of Nursing Workforce	30/06/2022	This will allow an integrated medium term plan to be developed and implemented to ensure nurse recruitment and retention better identifies and resolves nurse staffing	Delay

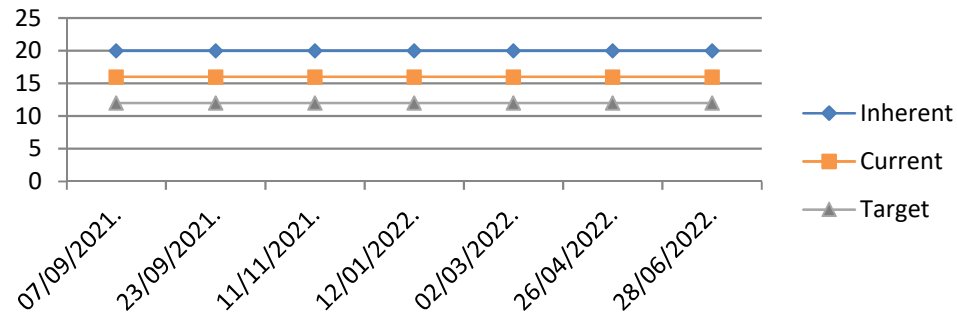
					challenges. July 2022 progress update - Dependant on the people strategy being developed and approved including investment in the oversees nurse programme and nursing team, anticipated completion by December 2022.	
	23095	Develop a business case for Corporate Nursing Workforce to provide and infrastructure to deliver the portfolio including an initial gap analysis to set up initially.	Mrs Alison Griffiths, Director of Nursing Workforce	30/11/2022	The infrastructure will enable the delivery of nursing workforce staffing and professional standards agenda/portfolio. July 2022 progress update - Business case developed and submitted, awaiting approval	On track

CRR21-15	**Director Lead:** Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 28 June 2022
	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:** 05 July 2022
		Target Risk Date: 31 October 2023

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.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. All Wales and North Wales Safeguarding procedures approved and in place. 2. BCUHB local work programmes in place and aligned to the national strategies which are regularly reported to Welsh Government.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group.

3. 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. 4. A standardised data report on key areas including Adult at Risk, Child at Risk and Deprivation of Liberty Safeguards (DoLS) is submitted to Safeguarding Forums in order that data is scrutinised and risks identified. 5. All mandatory training was amended to ensure compliance with the Social Services and Well-being [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. 6. The BCUHB Children's Division 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. 7. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 8. Welsh Government interim monies has been utilised to increase physical capacity out of hours. 9. Sexual Abuse Referral Centre (SARC) lead has been identified for the Health Board to support the implementation and compliance against the SARC accreditation. 10. Fully engaged and supporting the single unified Safeguarding Review lead by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding reviews and Homicide reviews. 11. Monies secured and implemented for the role of Independent Domestic Violence Advocate (IDVA) in Ysbyty Gwynedd and Ysbyty Glan Clwyd and further discussions are taking place to secure monies for Wrexham Maelor Hospital. 12. Health Board is leading on the emergency department Safeguarding Improvement Plans to support the implementation of Health Inspectorate Wales (HIW) findings and recommendations, the governance and reporting is to the Safeguarding performance group and overarching HIW action plans. 13. Undertaking bespoke supervision/peer support activities within high risk and low compliance areas/departments via Hospital Management Team's, reporting to 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 / Children's Board to scrutinise safeguarding mortality reviews. 6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government.

Gaps in Controls/mitigations
1. The increase in safeguarding activity, with enhanced complexity as a result of COVID, and the increase in victims recognised as a result of Domestic Abuse and Sexual Violence, refugees, modern day slavery/human trafficking and county lines, has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. This has resulted in the prioritisation of elements of service delivery aligned to the identified risk, being put in place. 2. The 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 a comprehensive digital clinical patient record reduces the identification of individual patient risks which results in the delay of information, communication and is time consuming. Safeguarding mandatory fields are in place within the Symphony system into Emergency Departments relating to non-accidental injuries for children under the age of 2 years, with alternative platforms in place when they 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. This is continued to be raised within multi agency forums with the attempt to support the overarching procedures whenever possible. 5. Named Doctor Safeguarding Children - Post is appointed to, awaiting the start date after a notice period of 3 months. Currently working in conjunction with the Paediatric Team to ensure local arrangements are in place to support the Safeguarding agenda/portfolio. 6. Compliance rates of training does not provide assurance against the knowledge and application of the training into clinical practice. Measuring understanding and application of training materials using desktop reviews and audit with arrangements in place to conduct a survey monkey to monitor understanding and awareness within the clinical settings. This provides targeted activity for low compliance and high risk areas.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls updated to reflect current risk position. 3. Mandatory fields implemented for Symphony system in the 3 Emergency Departments child at risk and domestic abuse, with new mandatory fields for Adults at Risk. 4. Post appointed to for the ‘Named’ Doctor for Safeguarding Children/Child at risk, awaiting start date for the post. 5. Request from the Risk Management Group in May 2022 for a trajectory to be developed due to the request to extend the Target Risk Date. Whilst the actions continue to progress and be developed, the trajectory is not achievable due to the reliance on Welsh Government timescales and setting up a task and finish group to refresh procedures. Also the new appointment of the named Doctor

will require time to evidence the impact of the role. Proposal anticipated to reduce the risk scoring in March 2023 to meet the Target Risk in October 2023. Other actions are dependent on the full participation and engagement on other areas and departments within the Health Board to fully engage and participate.
6. Action ID 18113 – Action delayed due to National agreement still awaited.
7. Action ID 18116 – Action closed as completed.
8. Action ID 18120 – Action delayed, whilst the Health Board is part of the group and fully engaged in the development of the revised guidance and legal process. Action remains delayed as led by Welsh Government.
9. Identification of new action ID 23507 for the Mental Health division to include the identification of resource to support a Safeguarding physical presence within the Mental Health Units.

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

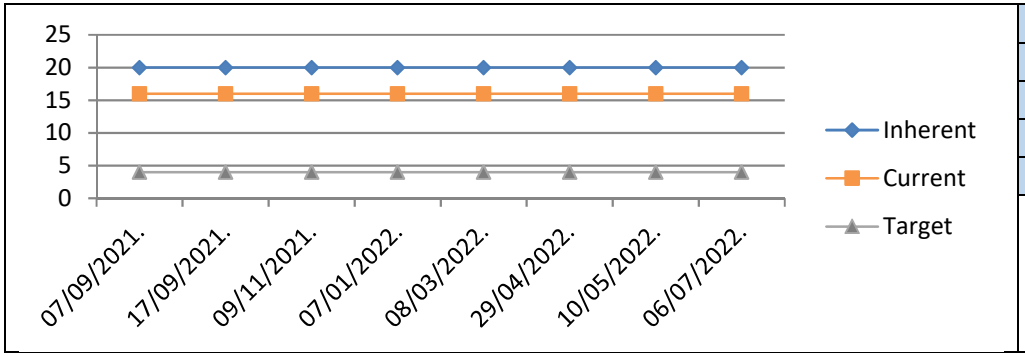
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	18113	Position of Trust and Section 5 (Professional Allegations) Implementation and monitoring of Workforce Safeguarding Responsibilities Standard Operating Procedure [Social Services and Well-being (Wales) Act 2014].	Michelle Denwood, Director of Safeguarding and Public Protection	20/12/2021	The process and the development of Key Performance Indicators' can be implemented across the Organisation to support safe recruitment and provide assurance relating to professional allegations / position of trust for Local Authority meetings. June 2022 progress update - National agreement still awaited for the publication of revised	Delay

					Position of Trust procedures. North Wales Safeguarding Board are supporting a Welsh Government Task and Finish Group to review the Position of Trust Procedure to support the development of regional procedures, this still causes a delay against internal BCU activity.	
	18116	To Implement and monitor strengthened governance and reporting pathways for Sexual Assault Referral Centre.	Michelle Denwood, Director of Safeguarding and Public Protection	10/01/2022	Action Closed 28/06/2022 Compliance with legislation and early identification of risk and harm. June 2022 progress update – Action closed as completed.	Completed
	18120	National development and implementation of Single Unified Safeguarding Review.	Michelle Denwood, Director of Safeguarding and Public Protection	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. June 2022 progress update - The Health Board is part of the national Task and Finish Group and fully engaged in the development of the revised guidance and legal process.	Delay

					Action remains delayed as led by Welsh Government.	
	21216	Utilise agreed funding for the increased activity within Safeguarding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the increased activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. June 2022 progress update - Integrated Medium Term Plan and the additional funding identified is now on the reserve list, with planned streamline of the business case for a total review of the Safeguarding structure. The recent notification of temporary Welsh Government monies is to be reflected within the Business case.	On track
	23507	Mental Health division to include the identification of resource to support a Safeguarding physical presence within the Mental Health Units.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	A single point of contact and physical presence will support the front line clinician to identify and to safeguard service users who may be at risk of harm. Will support the implementation of safeguarding practice and training.	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:** 06 July 2022
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 20 June 2023

There is a risk that insufficent Manual Handling training could lead to staff and patient injury, lost work time, Health and Safety Executive enforcement action (recent related Improvement Notices for Patient Falls, Patient Handling and Portering Load Handling risk assessments) and reputational damage. This may be caused by staff being unable to attend Manual Handling training due to a lack of dedicated training facilities, 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.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	1	4
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Health & Safety Strategy has been approved and implemented which includes Manual Handling. 2. Training Plan is in place specifically in relation to Manual Handling with compliance being monitored by the Mandatory Training Group. 3. Recruitment programme has been approved and is in place as part of the Health & Safety Business Case. 4. Risk assessments are in place to provide safe training environments. 5. A full review of the training was completed in August 2021 to ensure the training provided was in line with the All Wales Manual Handling Training Passport Scheme.	1. Regular oversight and review by the Occupational Health & Safety Team. 2. Reviewed at the Strategic Occupational Health and Safety Group. 3. Risk Management Group oversight. 4. Local Partnership Forum. 5. Health and Safety Executive inspections.

6. Suite of fully functional training rooms secured across the Health Board. 7. Datix system is monitored daily by the Health and Safety Team to review incidents and follow up on lessons learnt with services / departments. 8. Muscular-Skeletal Disorder Group re-instated to review trends in incidents and follow up improvement actions with services / departments. 9. Multi-Disciplinary Team including Manual Handling representative, set up and currently auditing compliance with patient handling risk assessments.	

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. Low compliance rates across the Health Board. There is a structured approach in place to increase mandatory training compliance, however with the lack of trainers in place improvement in compliance rates is challenging. 3. Lack of integrated booking system with the ESR system and ESR is not easy to use. Manual bookings currently in place. 4. Did Not Attend (DNA) at training sessions. A review of the rate of DNAs and evaluation of causes of none attendance remains a gap in the system. This will be undertaken by the new band 6 roles, when in post. This will strengthen the review of DNA's as part of the work programme. 5. Patient Handling refresher and orientation training should be delivered by clinically trained staff to comply with the Manual Handling Passport Scheme. The business case has been agreed and is being implemented, but this remains a gap in the controls until recruitment has been successful. Current compliance for Patient Handling refresher is now at 52%. 6. Gaps identified as a result of the Health & Safety Executive inspections in relation to completion of patient risk assessments, action plan developed to comply with HSE improvement notice and Multi-Disciplinary Team set up to audit internal compliance.

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position with the identification of additional controls. 2. Gaps in controls reviewed and updated to reflect current risk position including the increase of current compliance for Patient Handling refresher from 49% to 52%. 3. Action ID 17979 – Action remains delayed with shortlisting on current recruitment process with 4 candidates being offered an interview. 4. Action ID 18859 – Action delayed with the anticipated completion of the policy review by 30 September 2022. The ratification process will follow the completion of the policy review. 5. Identification of new action ID 23660 to consider alternative methods of Manual Handling Training delivery.

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	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.	Mr Peter John Joseph Bohan, Associate Director Health & Safety & Equality	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. July 2022 progress update - Shortlisted on current recruitment with 4 candidates being offered an interview. Following the interviews, consideration of alternative solutions to fill any gaps will take place. Confirmation awaited from the Manual Handling manager of a start date of the 01 August 2022.	Delay
	17980	Consider targeted training for both inanimate load handling and people	Mr Peter John Joseph Bohan,	01/04/2023	Target areas to ensure those with higher need for people handling training have been offered and	On track

		handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Associate Director Health & Safety & Equality		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. Targeted training on patient falls and handling risk assessments has commenced on 4 areas on the Wrexham site. The porters load handling risk assessments have been revised to include TILE. Supervisors have been re-trained on risk assessments and particularly load handling risk assessments. All porters to be given information, instruction and training on the risk assessments. An audit programme has commenced for both patient falls and patient handling risk assessments.	
	18859	Finalise, approve and implement Manual Handling Policy and Plan.	Mr Peter John Joseph Bohan, Associate Director Health & Safety & Equality	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. July 2022 progress update - Draft policy is in place, a review of the policy is underway in line with	Delay

					Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 September 2022. Ratification process will follow the completion of the policy review.	
	23660	Consideration of alternative methods of Manual Handling training.	Mrs Susan Morgan, Head of Health and Safety	30/09/2022	Looking at alternative training delivery will improve capacity to increase compliance rates to support the prevention of staff and patient injury.	On track

<table>
<tr><td rowspan="4">CRR21-17</td><td colspan="2">Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services</td><td>Date Opened: 26 July 2021</td></tr>
<tr><td colspan="2">Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 14 July 2022</td></tr>
<tr><td colspan="2" rowspan="2">Risk: The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.</td><td>Date of Committee Review: 05 July 2022</td></tr>
<tr><td>Target Risk Date: 21 July 2022</td></tr>
<tr><td colspan="4">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 Child and Adolescent Mental Health Services (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 the Emergency Departments 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.</td></tr>
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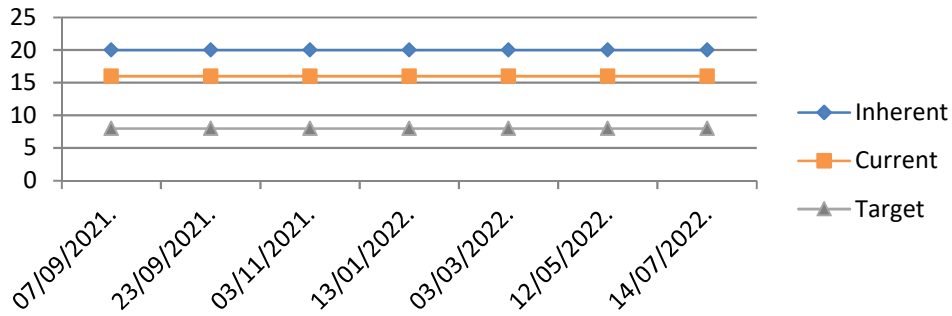


	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Area Team. 2. Collaborative working taking place between Mental Health, Emergency Departments, Paediatrics and Area Teams as part of the risk assessment and risk management processes. 3. Local individual risk assessment undertaken by nursing staff as part of the Paediatric Admission Process. 4. 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). 5. Paediatricians attend the s136 suites for children under the age of 16 years to undertake a holistic medical assessment. 6. CAMHS Psychiatry provide a 7 day service for S136 assessments between 9am to 5pm for young people up to their 18th birthday and out of hours telephone on-call rota. 7. CAMHS provide support to the s136 suites for young people under 16 years or those with complex needs where possible. 8. Collaborative/partnership working with Local Authority in finding placements for young people waiting on Paediatric wards. 9. Safeguarding discharge Standard Operating Procedure for young people in place. 10. Daily situation report (SITREP) reporting between Paediatrics and CAMHS, which includes incident notifications. 11. Analysis of intelligence from related incidents in generating organisational learning, awareness and fostering improvements.	1. A scoping exercise or report of Child and Adolescent Mental Health Services (CAMHS) Unscheduled/Crisis Care has been completed. 2. Related CAMHS risks are now regularly reviewed, scrutinised and discussed within a Pan-BCUHB 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 Welsh Government, joined with Mental Health Division on a quarterly basis.

Gaps in Controls/mitigations
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 Local Authority placements or shared safe environments within which young people can be assessed or discharged to. Looking and considering alternative safe environments/accommodation across all health economy areas and Local Authority partners. 3. Lack of agreed consistency, threshold and standardisation for reporting related incidents across the Health Board in relation to Mental Health patients on Paediatric wards. Incidents are being reported within areas and reviews are undertaken at Child and Adolescent Mental Health Services (CAMHS) and paediatric safety meetings.

Progress since last submission
1. Controls in place reviewed to reflect current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Following comments at the last Risk Management Group in relation to the target risk due date of the 31/10/2022 being achievable, due to the release of the new NICE guidance now being further delayed until the 07/09/2022 this will impact upon the target risk due date being met in relation to the implementation of the requirements from the guidance. Proposal to extend the target risk due date to the 31/03/2023 to allow sufficient time for completion of written policies and procedures and implementation which will also result in further staff training in line with the NICE guidance. 4. Action ID 17957 – Action closed as 'No wrong door' strategy for Children and Young people approved, implementation being led by the Children's Sub Group of the Regional Partnership Board. 5. Action ID 19594 - Action closed as completed. 6. Action ID 17963 – Action remains delayed with further delays to the release and publication of the new NICE guidance being put back to the 07/09/2022, which will result in further delay to completing the action. Proposal to extend the action due date to the 31/12/2022 to allow sufficient time to complete and implement the action following release of the guidance in September 2022, the delay in publication is out of the Health Boards control.

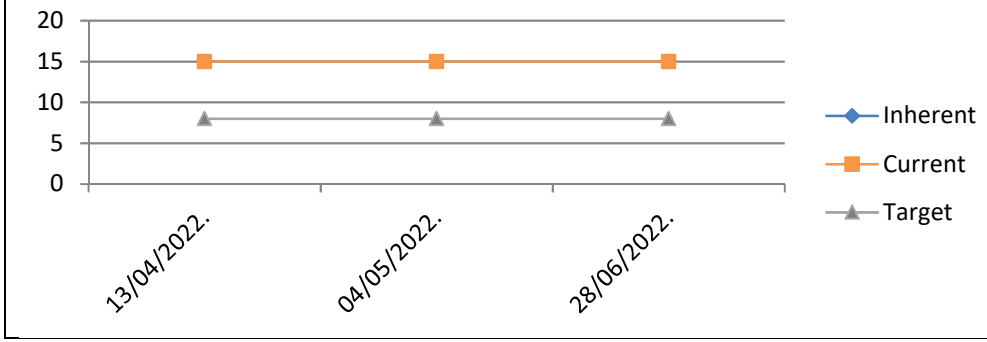
Links to	
Strategic Priorities	**Principal Risks**
Improved USC (Unscheduled Care) pathways Integration and improvement of MH (Mental Health) Services	BAF21-01 BAF21-08

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways. July 2022 progress update - Due to staff sickness, action has been delayed, meeting planned to update current position during August 2022.	On track
	17957	To use a collaborative multi agency partnership approach in addressing the needs of young people accessing Child and Adolescent Mental Health Services (CAMHS).	Marilyn Wells, Head of Nursing	31/10/2022	Action Closed 14/07/2022 This will enable us to meet the needs of young people before crisis occur as most of their needs are pyscho-social and not just Mental Health. July 2022 progress update - No wrong door strategy for Children and Young people approved, implementation being led by the Children's sub group of the Regional Partnership Board.	Completed
	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. July 2022 progress update -	Delay

					Action remains delayed with further delays to the release and publication of the new NICE guidance being put back to the 07/09/2022, which will result in further delay to completing the action. Proposal to extend the action due date the 31/12/2022 to allow sufficient time to complete and implement the action following release of the guidance in September 2022, the delay in publication is out of the Health Boards control.	
	17964	Training and awareness raising for relevant professionals in supporting and assisting young people in crisis. For example: Paediatric staff/ Emergency Department staff, Local Authority and North Wales Police.	Marilyn Wells, Head of Nursing	31/10/2022	Create awareness and develop skill in assessment and improve staff morale. July 2022 progress update - Following review of the training requirement, it was identified that there is a need for the development of an ongoing training programme rather than one off training sessions, therefore this will require some scoping and resourcing. This action will be dependent on, and linked to, the requirements within the new delayed NICE guidance.	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. July 2022 progress update - East Area pilot reviewed and currently paused due to lack of activity, further planning required.	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 Community Services	01/02/2022	Action Closed 14/07/2022 The Risk Assessment and audit process will support the reduction in the risk score whilst recognising that the paediatric wards cannot be a completely ligature free environment.	Complete
	21236	Implementation of recommendations following the Delivery Unit Crisis Care Review.	Marilyn Wells, Head of Nursing	31/10/2022	Provide further assurance following a review by an external body and the implementations of any recommendations to support the development of high quality and safe care. July 2022 progress update - Final report received by the Health Board, implementation of recommendations ongoing.	On track
	23091	Progress with recruitment to bespoke campaign for Child psychiatry.	Mrs Louise Bell, Assistant Area Director	31/10/2022	Implementation will help to deliver a safe and sustainable service within BCU. July 2022 progress update - Recruitment remains ongoing.	On track

CRR22-18	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 10 December 2021
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 28 June 2022
	Risk: Inability to deliver timely Infection Prevention & Control services due to limited capacity	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 31 March 2024
There is a risk that Infection Prevention (IP) will not be able to provide an effective service to BCUHB. This may be caused by the relative limitations in size of the service (taking the size of the Health Board into account) and the current significant unfilled vacancies. This could lead to an increase in healthcare associated infections, patient harm and loss of reputation to the organisation.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	3	15
Current Risk Rating	5	3	15
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Infection Prevention policies and procedures in place to ensure best practice and standardisation, monitored by Infection Prevention Sub Group. 2. Senior members of the Infection Prevention Team (IP) are providing support to other areas as well as their own. 3. Reviewing and prioritising the programme of work and workload for all staff in the team e.g. ensuring experienced Infection Prevention nurses are not doing admin tasks. 4. Prioritising/focussing on areas of concern/'hot spots' which may result in less visibility in areas in which Infection Prevention risk is lower. 5. Reviewing and prioritising attendance at meetings and on groups etc. 6. Employed senior manager via an agency to support the team. 7. Supporting and protecting existing team with measures including weekly team meetings and reviews.	1. Infection Prevention Audits reported at local groups and to the Infection Prevention Sub Group. 2. Alert organism statistics. 3. Compliance with Welsh Health Circular 2021 Number 028 reported to Infection Prevention Sub Group and to Quality Safety and Experience Committee. 4. Patient incident reviews. 5. Regular review of Datix Incidents which are alerted to the team when logged on the system for learning purposes and for rectification.

	6. Outbreaks are monitored, managed and reported to Infection Prevention Sub Group. 7. Regular review of Infection Control and Prevention trajectory reported at Local Infection Prevention Groups. 8 Risk regularly reviewed at Infection Prevention Sub Group.

Gaps in Controls/mitigations
1. There is a national issue recruiting into Infection Prevention and Control roles, particularly at a senior level (7s and above). Senior members of the Infection Prevention Team (IP) are providing support to other areas as well as their own. 2. Experienced Infection Prevention Agency nurses only want to work remotely. Staff members working remotely are required to review policies, produce reports which in turn releases non-remote working staff to undertake clinical work. 3. The 2 vacant band 8bs have been advertised but there were no suitable applicants. Post re-advertised and currently cross covering within the service with senior members of the Infection Prevention Team (IP) providing support to other areas as well as their own. Recruited internally to senior 8a level supported by other senior Infection Prevention staff.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Actions reviewed and progress provided against the actions.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-09

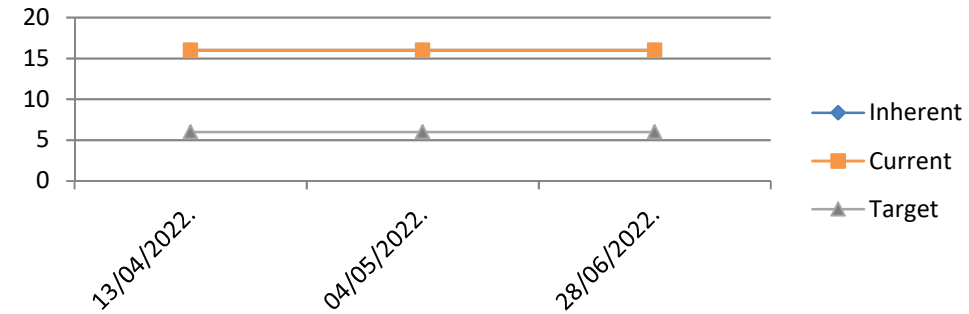
Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	20654	Use Infection Prevention Champions to promote good practice.	Mr Dafydd Williams, Infection Prevention Nurse	30/09/2022	To help promote IP in their own departments whilst visibility of the IP team will be low June 2022 progress update - Re-started Infection Prevention training sessions 2 per month and established weekly forum to support IP champions with queries, new guidance etc.	On track
	20659	Business case for expanding current team.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	To outline case to the Executive Team that more staff are required and obtain approval for funding.	On track
	21696	Recruit to current vacant Infection Prevention posts.	Mrs Andrea Ledgerton, Specialist Matron IP	30/09/2022	Fill current vacant posts June 2022 progress update - internal promotions and lower band promotions in progress.	On track
	21698	Work with Communications and Workforce to develop a Recruitment Campaign for Infection Prevention nurses.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To help attract IP staff to BCU.	On track
	21702	Draw up a development programme and a	Ms Rebecca Gerrard, Director	29/07/2022	To develop own IP staff and support recruitment and	On track

		succession plan to ‘grow our own’.	of Nursing Infection Prevention & Decontamination		retention June 2022 progress update - Internal promotions and additional support from senior staff in place action ID 21696 is in line with this action.	
	22927	Promote Infection Prevention Massive Open Online Course education programme.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	30/09/2022	To improve knowledge, practice and compliance with IP in wards and departments. June 2022 progress update - Promoting via IP Sub Group with significant interest, however awaiting future course dates to be released.	On track

CRR22-19	**Director Lead:** Executive Director of Nursing and Midwifery	**Date Opened:** 21 February 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 28 June 2022
	Risk: Potential that medical devices are not decontaminated effectively so patients may be harmed.	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 31 March 2024

There is a risk that medical equipment will not be decontaminated appropriately. This is caused by a number of factors including:
1. Sterile service departments air handling units require upgrade/replacement, some equipment and the track and trace system requires replacement and at WM hospital the steam generation plant and electrical infrastructure requires an upgrade.
2. Poor, outdated facilities for decontaminating dental equipment, scopes and probes and washer disinfectors at YGC and WM are at end of life. Also they rely on a paper track and trace system.
3. There is a lack of robust approved SOPs for decontamination.

This could lead to transmission of infection, vital treatments and services having to stop, patient complaints and litigation, enforcement action, improvement notices, multiple breaches in statutory duty, critical reports and adverse media coverage.



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Decontamination audits have been increased to twice yearly. 2. A capital replacement programme is used to address aged sterilising equipment in Sterile Services and Disinfection Units. 3. The Decontamination Group has been re-established following the latest COVID peak to ensure monitoring, progress and learning. 4. Disseminating good practice from the new Endoscopy Unit at Ysbyty Gwynedd to other Units across the Health Board.	1. Regular review by Decontamination Group. 2. 6 monthly decontamination audits by Infection Prevention Team. 3. Decontamination audits by Authorised Engineers. 4. Sterile services departments have audits carried out by notified bodies in

5. Single use scopes are being used where possible removing the requirement for decontamination. 6. Engineering support is presented from the in-house facilities team and is generally to a high standard. 7. Governance systems are managed by the Authorised Persons (Decontamination). 8. The Executive Director for Infection Prevention has been alerted and requested an overall risk assessment which has been completed. 9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership.	accordance with the Medical Device Directives/Regulations. 5. Risk register on decontamination.

Gaps in Controls/mitigations
1. The Decontamination Advisor currently on a period of extended leave. Staff member currently acting up into the position to cover this period. Exploring with Agencies whether external appointments could be made. 2. Some Consultants do not want to use single use scopes – Looking at exploring alternative methods of decontamination for the re-usable scopes. 3. There are not many risks on Datix related to Decontamination and there is inconsistency in scoring e.g. one site has a risk related to track and trace in Sterile Services and Disinfection Units scoring 10, another scores it 4. There needs to be review of all risks relating to Decontamination and updates requested from de-contamination group members. 4. Potential disruption to the safe delivery of decontamination service due to the ageing equipment and estate is being mitigated against by establishing contingency plans.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Groups met to review inconsistency and identification of risks with further meetings scheduled to review. 4. Action ID 22146 – Action delayed, terms of reference drafted and awaiting approval by Infection Prevention Sub Group. 5. Action ID 22932 – Action completed, all actions have been addressed and reported to the Decontamination Group.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-02 BAF21-09

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	22146	Revise and approve the Decontamination group terms of reference.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	30/06/2022	To ensure appropriate and robust membership of the group and a process of monitoring and continual improvement. Terms of reference drafted and awaiting approval by Infection Prevention Sub Group on the 30th July 2022.	Delay
	22147	Policies and Standard Operating Procedures written/revised and approved for Decontamination.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	As part of good governance and so staff are aware of their responsibilities and roles and how to decontaminate medical devices. The action will focus on policies and procedures due for review by the end of 2022.	On track
	22148	Purchase new washer disinfector for endoscopy unit at Ysbyty Gwynedd.	Mrs Joanna Elis-Williams, Head of Secondary Care Office	31/08/2022	To provide resilience in the event of a machine failure and allow ENT scopes to be decontaminated June 2022 progress update - 80% of ENT scopes are currently going through the endoscopy unit using the current machines.	On track

	22149	Meet with key stakeholders re scope issues at Ysbyty Glan Clwyd and Wrexham Maelor.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/07/2022	To highlight key issues and establish a way forward June 2022 progress update - Each site establishing their own groups to address the issues.	On track
	22152	Community Dental Services, Assets and Facilities group to reform and form a plan for moving forwards.	Peter Greensmith, Business Support Manager - Dental	31/03/2023	To establish formal timeframe and funding for plans.	On track
	22153	Estates to meet with sterile services managers.	Mr Arwel Hughes, Head of Operational Estates	30/09/2022	To revise risk assessments and make plan for upgrading Sterile services departments Action will take place following a review by Shared Services to identify priority areas, anticipated by end of July 2022.	On track
	22931	NHS Wales Shared Services review of Sterile Services and Disinfection Units.	Mr Arwel Hughes, Head of Operational Estates	31/07/2022	To outline the specific risks and help BCU identify priorities. June 2022 progress update - Review carried out and anticipated report by end of July 2022.	On track
	22932	Carry out an audit of decontamination of all ultrasound machines and the use of ultrasound gel.	Sandra Lorraine Jones, Decontamination & IP Sister	30/06/2022	Action Closed 28/06/2022. To ensure machines are being decontaminated appropriately and sterile gel is being used	Completed

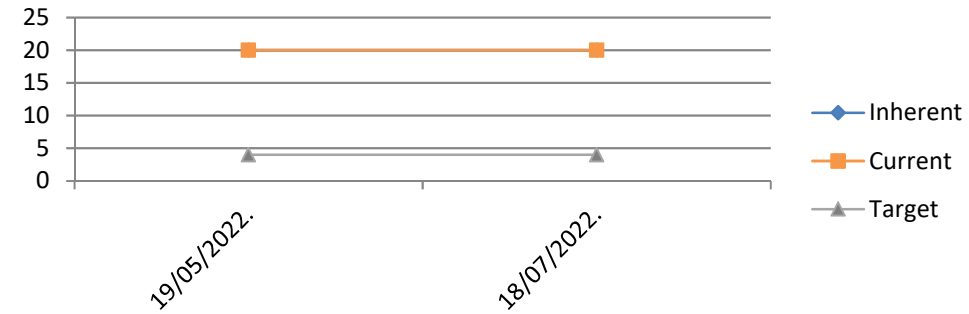
					where indicated to reduce infection risks. Completed and all action have been addressed and reported to the Decontamination Group.	
	23024	To seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/12/2022	To demonstrate the improvement and high standards achieved by Endoscopy at the Unit.	On track

CRR22-22	**Director Lead:** Executive Medical Director	**Date Opened:** 03 November 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 18 July 2022
	Risk: Delivery of safe and effective resuscitation may be compromised due to training capacity issues.	**Date of Committee Review:** 05 July 2022
		Target Risk Date: 30 September 2022

There is a risk that BCUHB staff cannot access their mandatory resuscitation training.

This is due to several factors including:
A lack of 'fit for purpose' training accommodation and equipment across the sites; Insufficient numbers of Resuscitation Officers/Trainers.

This could lead to failure to deliver effective patient care resulting in preventable harm or death from impaired or unsuccessful resuscitation. Additional risk of financial claims against BCUHB resulting from preventable harm/deaths.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Resuscitation Policy and Guidance is in place for the Health Board with compliance overseen by the Resuscitation Committee. 2. Training plan in place governed by the UK core skills framework. 3. Resuscitation training is a mandatory training programme across the Health Board. 4. Delivery of the training has been re-designed to increase capacity, this has resulted in the reduction of clinical staff's time away from clinical duties. 5. Systems and processes are in place to manage attendance at training sessions. 6. Additional temporary training footprint sourced within the Central region.	1. The risk is reviewed monthly by the Resuscitation Services senior management team, and is presented to the Resuscitation committee on a quarterly basis. 2. Training figures and capacity are regularly reviewed on a quarterly basis

7. Hospital Management Team engaging with Central site clinical areas to establish accurate data on the training needs within areas and to ensure attendance mandate is adhered to. 8. Assurance that all resuscitation attempts by the emergency response teams are led by staff who hold the current Advanced Life Support qualification for the respective teams. The assurance of this is being supported by the reinstatement of the daily test bleeps for the teams in Central, and with a log of the current advanced resuscitation qualification status recorded each day as team members respond to the test bleep. Where an 'expected team leader' does not hold the required qualification, then the team leadership role is deferred to another team member who does hold the required qualification.	at the Resuscitation Committee via site reports. 3. The risk has been presented to PSQ (Performance Safety & Quality), and Clinical Effectiveness groups (13th October 2021).

Gaps in Controls/mitigations
1. Despite controls above, there remains a deficit of approximately 2000 training places per year for resuscitation training at UKCSTF Level 3 on the Central locality. 2. There is no designated training accommodation on the Central locality. This lack of accommodation is in breach of the national standards as set by the Resuscitation Council UK. Continued breach could result in loss of course centre license on the Central locality which would cease all level 3 training from the site. The identified potential accommodation requires approximately £136k (subject to contractors quotation) to make safe and fit for purpose and there is currently no identified funding source. Identification of this funding source has been asked for from Central Site Management with support from Estates / Planning / Finance teams. 3. With particular relevance to the Ockenden report is the Newborn Life Support (NLS) provision which is running on limited capacity both East and West, and is at 0% capacity in central with no NLS training at all due to the lack of availability of suitable training accommodation. 4. The Audio-Visual system required for these courses is failing on the East site. In May 2022 two of the systems failed during the delivery of an Advanced Trauma Life Support course, which required those rooms to run without these resources for the remainder of the course. This impeded the course delivery and will feature in the course report from the course director to the Royal college of Surgeons. The failure of the AV system will impact on every course run in the East venue and requires replacement. 5. There is currently no functional and reliable cardiac arrest audit within BCUHB. Therefore rates (other than raw switchboard data), outcome data, and improvement opportunities cannot be reliably established. Actions are in place to develop a functional audit of 2222 calls (See actions for progress to date).

Progress since last submission
1. Controls in place reviewed and updated to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Action ID 23207 – Action closed and completed, training rooms on the YG site were made available for Central site staff. 4. Action ID 23208 – Action delayed with plans having been drawn up, and awaiting a quotation from the contractor via the Planning department. 5. Identification of new action ID 23753 to reinstate emergency team test bleeps, and assurance around team resuscitation qualifications. Action now closed as completed with test calls now established and staff are being asked to provide the training information requested. 6. Identification of new action ID 23754 to complete data collection design for 2222 electronic audit with Informatics support.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Strengthen our wellbeing focus Primary and community care Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-04 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	19313	Provision of permanent and fit for purpose training and office accommodation on the YGC site.	Mrs Sarah Bellis-Holloway, Resuscitation Services Manager	30/09/2022	“While it will not mitigate the clinical absence of Resuscitation Officers from the acute site, or loss of other non-training activity; the identification of a suitable commercial venue in which we can provide all levels of resuscitation training, along with F&P funding approval will	On track

					lower the score in relation to training from 20 to 4 in the short term (lease period). This will mitigate the risk until a permanent venue within the YGC footprint is developed." July 2022 progress update - As of 18/07/2022, we are still awaiting a formal quotation and timescale for the required estates work. Once this has been received we will be in a position to know if the Action due date remains feasible or if a review and extension request will need to be submitted.	
	23207	Allocation of training room in West to support Central site with ILS/PILS training as a short term.	Mr Christopher Glyn Shirley, Resuscitation Officer	30/06/2022	Action Closed 18/07/2022 The action will enable us to mitigate and manage this risk by delivering training in the short term. July 2022 update - This action was completed and training rooms on the YG site were made available for Central site staff, however uptake was poor (<=25% attendance) with reasons given being lack of ability or willingness of staff to travel for training, and inability for staff to	Completed

					be released from clinical areas. Additional rooms since become available in the Optic and a single room in the CTU has been made available on a temporary basis. This has meant that many of the sessions for the YG site, have been able to be repatriated into the Central region.	
	23208	To identify funding stream for the required estates work by the Central Site Management with support from estates/Planning/Finance colleagues.	Reena Cartmell, Deputy Director of Nursing	30/06/2022	This action will enable a building to be secured for delivering training on the Centre Site thereby helping mitigate and manage this risk in the long-term. July 2022 progress update - Agreement in principle has been made on the layout and occupancy of the CTU building as shared with Resuscitation Services. The plans have been drawn up, and we are awaiting a quotation from the contractor via the Planning dept. Once the quotation is received then the Central HMT will have knowledge of the amount of funding they need to source.	Delay
	23753	Reinstate emergency team test bleeps, and assurance	Mr Christopher Glyn Shirley,	30/06/2022	Action Closed 15/06/2022 This will provide assurance that	Completed

		around team resuscitation qualifications	Resuscitation Officer		all resuscitation attempts are led by staff who are suitably trained, and current with the National guidelines for resuscitation by the relevant awarding body. July 2022 update - Test calls are now established and staff are being asked to provide the training information requested. Reports received from switch each day, and where needed, staff (bleep holders) are being contacted to action non response to the test or to re-assign team leadership if needed.	
	23754	Complete data collection design for 2222 electronic audit with Informatics support.	Mr Christopher Glyn Shirley, Resuscitation Officer	15/08/2022	Reliable and robust data will enable the health board to provide accurate data on cardiac arrest rates, and report on outcomes. It will also enable analysis of opportunities to reduce patient harm, reduce cardiac arrests, and aim to help to prevent unplanned critical care admissions.	On track

Appendix 2 - Full list of all Corporate Risk Register (CRR) Risks including Current Risk Score

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR20-01	Asbestos Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-02	Contractor Management and Control.	Executive Director of Finance	Quality, Safety and Experience	15
CRR20-03	Legionella Management and Control.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-04	Non-Compliance of Fire Safety Systems.	Executive Director of Finance	Quality, Safety and Experience	16
CRR20-05	Timely access to care homes.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	20
CRR20-06	Informatics - Patient Records pan BCU.	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR20-07	Informatics infrastructure capacity, resource and demand – Risk entry closed by Partnerships, People and Population Health Committee			
CRR20-08	Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
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			

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-11	Potential Exposure to RansomWare and Zero-day Cyber Risks Attacks.	Chief Digital and Information Officer	Partnerships, People and Population Health	20
CRR21-12	National Infrastructure and Products	De-escalated by Partnerships, People and Population Health Committee, risk being managed at Tier 2		
CRR21-13	Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce).	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16
CRR21-14	There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Mental Health and Capacity Compliance	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.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	Quality, Safety and Experience	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	Quality, Safety and Experience	16
CRR21-17	The potential risk of delay in timely assessment, treatment and discharge of young people accessing CAMHS out-of-hours.	Executive Director Transformation, Strategic Planning, And Commissioning	Quality, Safety and Experience	16
CRR21-18	Inability to deliver timely Infection Prevention & Control services due to limited capacity.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	15
CRR21-19	Potential that medical devices are not decontaminated effectively so patients may be harmed.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	16

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR21-20	There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents.	Executive Director of Public Health	Partnerships, People and Population Health	20
CRR21-21	There is a risk that adults who are a overweight or obese will not achieve a healthy weight due to engagement & capacity factors	Executive Director of Public Health	Partnerships, People and Population Health	16
CRR21-22	Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	Executive Medical Director	Quality, Safety and Experience	20
CRR22-23	Inability to deliver safe, timely and effective care.	Executive Director of Nursing and Midwifery	Quality, Safety and Experience	20
CRR22-24	Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	Executive Director of Workforce and Organisational Development	Partnerships, People and Population Health	15
CRR22-25	Risk of failure to provide full vascular services due to lack of available consultant workforce.	Executive Medical Director	Quality, Safety and Experience	15
CRR22-26	Risk of significant patient harm as a consequence of sustainability of the acute vascular service	Executive Medical Director	Quality, Safety and Experience	
CRR22-27	Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping – Vascular services.	Executive Medical Director	Quality, Safety and Experience	15

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
CRR22-28	Risk that a significant delay in implementing and embedding the new operating model, resulting in a lack of focus and productivity.	Executive Director of Workforce and Organisational Development		
CRR22-29	Risk that a loss of corporate memory as a result of the departure of key staff during the transition to the Operating Model.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-30	Risk that a lack of robust and consistent leadership can contribute to safety and quality concerns	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services		
CRR22-31	Risk of a capacity & capability gap during the transition of staff departing the organisation through the VERS process and the recruitment of people both internally and externally to posts within the new Operating Model	Executive Director of Workforce and Organisational Development		

Risk Key Field Guidance / Definitions of Assurance Levels V2

BAF / Risk Template Item	Please refer to the Risk Management Strategy 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 V2

	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	- 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	- 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.

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

Templed adroddiadau'r Bwrdd/Pwyllgor
Board/Committee report template

Teitl adroddiad: ***Report title:***	**Mental Health and Learning Disabilities (MH&LD) Divisional Improvement Plan – Briefing Paper**		
Adrodd i: ***Report to:***	BCUHB Corporate QSE Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022		
Crynodeb Gweithredol: ***Executive Summary:***	The purpose of this paper is to provide an update to the Board on progress made to date in the development and delivery of the MH&LD Divisional Improvement Plan. It seeks to provide assurance regarding the mechanisms that have been put in place to ensure there is increased grip and oversight on delivery of the plan across the Division. The plan brings a structured methodology to the improvement work. This has been supported by the BCUHB Transformation and Improvement team. Delivery of the plan will be overseen via the revised Programme governance structure that has been put in place across the Division to oversee Programme delivery. QSE will be aware that during 2019-2022, the Division underwent a number of inspections, and these all identified some critical areas where improvement was required in the way that services were being delivered across the Division and across a number of domains. The plan is underpinned by detailed analysis and triangulation of these multiple sources of information. The six pillars – "work streams" - of the plan reflect the thematic elements of the analysis/triangulation, creating a structured and co-ordinated programme of work. This paper provides the Board with a detailed Improvement plan, and the critical actions that will be implemented. Some of these will be progressed at pace, whilst others will require more understanding of the root cause of the problem so that sustainable solutions can be put in place. The paper also describes the mechanism by which the Division will assure itself regarding sustainable delivery. An integral part of delivering the plan will be embedding learning amongst across the Division to ensure sustainable improvement happens. The Divisional Improvement plan represents the portfolio of work streams that are being undertaken across the Division and includes Service developments, Operational improvement, and Service Transformation. These work streams include initiatives to enhance people, organisational development, culture-based improvements, and safety, in addition, going forward there will be a strengthened focus on the outcome approach.		
Argymhellion: ***Recommendations:***	The Board/Committee is asked to review the proposed update on the development of the MH&LD Divisional Improvement Plan.		
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of MHLD		
Awdur yr Adroddiad: ***Report Author:***	Carole Evanson, MH&LD Divisional Director of Operations		
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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

This Improvement plan is stronger in comparison to previous submissions. It will require continual management and oversight and review. It has been constructed in collaboration with involvement of key stakeholders from "Ward to Board" and is owned by the Division. Evidence based approaches to improvement, and programme management have been adopted throughout. However, the Division are in the initial stages of implementation and on that basis have scored assurance as 'Partial.' It is anticipated that there will be considerable progress in delivery of the plan and that assurance will move to an acceptable level by Quarter 3.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The strategic implications of the Divisional Improvement Plan and alignment of work streams relates to the following: ➢ Priorities within "A Healthier Wales: long term plan for health and social care" ➢ Together for Mental Health North Wales Strategy ➢ North Wales Learning Disabilities Strategy ➢ Alignment with the BCUHB Integrated Medium Long-term Plan ➢ Supports delivery against Targeted Intervention requirements ➢ Aligned with the Divisional Clinical Strategy/Clinical Effectiveness ➢ Supports integration agenda and aligns with BCUHB Operating Model ➢ Linkages with delivery of the Digital Strategy ➢ Covid-19 response and recovery ➢ Strengthen our wellbeing focus ➢ Recovering access to timely planned care pathways ➢ Improved unscheduled care pathways ➢ Integration and targeted improvement of mental health services ➢ BCU Estates Strategy ➢ People Stronger Together Strategy ➢ Mental Health Measure Standards
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The MH&LD Divisional Improvement Plan is the opportunity to include and align all key projects, streamline the process of governance, identify interdependencies, and enhance efficiencies within the total process of programme and project delivery. The plan addresses the improvements identified as being required by HIW.
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal?	Do/Naddo *N*

In accordance with WP7 has an EqlA been identified as necessary and undertaken?	Gweithdrefn ar gyfer Asesu Effaith ar Gydraddoldeb WP7 *WP7 Procedure for Equality Impact Assessments* Impact Assessments will be completed once the proposals have been approved.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *N* Os naddo, rhowch esboniad yn ymwneud â'r rheswm pam nad yw'r ddyletswydd yn *berthnasol* Impact Assessments will be completed once the proposals have been approved.
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	(crynodeb o'r risgiau a rhagor o fanylion yma) BAF21-07 There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The financial implication of the plan is being progressed.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The Division has had business cases approved for recruiting project management capacity to support implementation of the Improvement Plan, and are currenlty in place. Substantive roles aligned to service improvement and development priorities are being recruited to, with the aim of staff being in post by the end of October 2022.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report has been reviewed internally by senior leadership in consultation with the BCUHB Transformation and improvement team, Clinical and operational leads and project managers acorss the Division. The Plan will be included within consultation workshops for the Together for Mental Health Strategy takiing place Sep, Oct, Nov 2022.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-07 There is a risk that the leadership model is ineffective and unstable. This may be caused by temporary staffing, unattractive recruitment and high turnover of staff. This could lead to an unstable team structure, poor performance, a lack of assurance and governance, and ineffective service delivery.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: Gweithredu argymhellion **Next Steps:** • Approve the Assurance report provided • BCU Corporate QSE Committee to review progress in December 2022 on actions achieved to date and outcomes delivered	

Rhestr o Atodiadau:
Dim
List of Appendices:

MH&LD Divisional Improvement Plan

Appendix 1 – Navigation

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Appendix 2 – Timescales

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Appendix 3 – House

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Appendix 4 – Tier 1 Work stream

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Appendix 5 – Tier 2 Sub Themes

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Appendix 6 – Tier 3 Task Level detail

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Appendix 7 – Key Performance Indicators

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Appendix 8 – Example Power BI Dashboard

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Appendix 9 – Example Plan on a page

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Appendix 10 – Phases

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PROGRAMME ON A PAGE: HIGH LEVEL SUMMARY - DRAFT			
Mental Health and Learning Disabilities			**PLAN STATUS**
Executive Accountable Owner	Teresa Owen	TIMEFRAME FOR DELIVERY	**Plan Developed** 23/05/2022
Senior Responsible Owner	Carole Evanson		**Date Revised** 22/07/2022
Workforce Lead	Claire Thomas-Hanna		**Version** V0.16
Project Managers	See Workstream Leads below		

REPORTING FRAMEWORK
Divisional SLT Business
Divisional Workforce Group
OLM

APPROVALS				
DSLT	QIA	EQIA	DPIA	OLM

PROGRAMME OUTCOMES	
Outcome Number	**Outcomes to be Delivered**
	High Priority - Short Term (0-6 months)
1	**MH&LD Divisional Workforce plan** - will be in place, with agreed key milestones
2	**Workforce will be respected and empowered,** appropriately informed and trained and demonstrate the BCU values whilst supporting people with skill and compassion.
2a	**Culture** in the organisation will be improved.
2b	**Workforce Transformation - Service changes and developments** will be managed by inspirational and skilled leaders and the values of kindness and compassion will be central within the organisation **(workstream 3 ref: 2b)**
3	**Comprehensive recruitment plan (for priority groups)** - there will be a clear plan describing a recruitment plan for Nursing, HCA's, A & C and Medical staffing for the Division which will transform workforce recruitment from reactive to proactive **(workstream 3)**
3a	**Just R Marketing Campaign** will be in place, with agreed key milestones **(workstream 3 ref 3a)**
4	**Welsh Essential roles** will have appropriate Job Description and Person Specifications in place **(see workstream 3 ref: 4)**
5	**Coaching programme implementation** - a Coaching Programme will be in place with an increased number of trained coaches, linking into the wider organisation **(workstream 2 ref:5)**
6	**Emotional Wellbeing support for staff** - every member of staff will be offered flexible and responsive support, at the right time, through the systematic availability of emotional support including signposting to additional services as appropriate **(worksream 1 ref:6)**
7	**Manager's Handbook** - will be available, describing key processes, systems and procedures to improve staff management and increase leadership skills **(workstream 1 ref:7)**
8	**Sickness theme analysis** - a procedure will be in place to explore and review sickness in different parts of the Division to identify any relevant themes, support requirements and identify interventions **(see workstream 1 ref:8)**
9	**Career pathway development -** there will be clearly defined career pathways, including development of an Apprenticeship Programme for A & C staff. **(Worksream 2 ref: 9)**
10	**Skills and competencies framework** - a description will be in place of what specific skills are required for staff groups working in the in distinct service areas and specialisms **(Workstream 2 ref: 10)**
11	**Training plan to address skill gaps and priority areas** - gaps in training will be reviewed and a training plan for suicide awareness, WARRN and risk assessment training will be in place **(Workstream 2 ref:11)**
12	**Demand and capacity analysis (whole system) -** Inpatient and Community services will be adequately resourced having the right staff, at the right time with the right skills **(see workstream 5 ref:12)**
13	**Comprehensive retention plan** will be in place with key milestones **(workstream1 ref:13**
14	**Estates** will be scoped to ensure adequate provision for current and future service needs. (linked to Estates Programme)
15	**MH&LD Joint Partnership Group Meeting** will be in place to colloboarate and engage with staff side reperesentative.
	Medium Priority - Long term (>12 months)
16	**MH&LD Staff Induction booklet** - describing key aspects of the Division and induction requirements will be available **(Workstream 2 ref: 16)**
17	**Leadership development opportunities** - a description of Leadership skills development opportunities and expectations will be developed and made available **(workstream 2 ref:17)**
18	**MH&LD TRiM support following incidents** - a process will be in place for supporting staff through incidents as well as the provision of emotional support, including post-incident support, and increasing TRiM support **(Workstream 1 ref:18)**
19	**Student feedback** - on MH&LD placements will be disseminated to all staff and reviewed by the MH&LD Workforce Group **(Workstream 2 ref: 19)**
20	**New Starter Questionnaire** - themes from the New Starter Questionnaires will be available and shared with the MH&LD Workforce Group, in addition to themes from Exit Interview **(Workstream 1 ref: 20)**
21	**Reflect & learn survey** - a clear description of themes collated from the 'MH&LD Reflect & learn survey' will be shared with staff in all services including the themes from the BCU staff survey to be incorporated into service plans **(see workstream 1 ref:21)**
22	**WW&U description** - there will be a clear description of how the WW&U Service links with the Respect & Resolution processes **(workstream 1 ref: 22)**

Benefit Number	**Organisation Benefits to be Delivered**
1	**Quality / Access / Patient Experience / Optimum Capacity / Staff Wellbeing** - staff retention will increase, applicants will increase and the number of vacancies will reduce.
2	**Quality / Staff Wellbeing** - targets for mandatory training , PADRs and supervision will improve by 5.7% against a Q1 20/21 baseline
3	**Staff Wellbeing / Optimum Capacity / Value assurance** - Relative reduction in the costs of the variable pay bill due to improved retention and sickness/ absence rates (in the context of predicted increases due to post Covid), decrease reliance on agency staffing and spend
4	**Staff Wellbeing / Optimum Capacity** - staff will report improvements in their work/ life balance and quality of their work experience
5	**Staff Wellbeing / Optimum Capacity -** MHLD will be viewed as an excellent employer which people want to work for, and stay with
6	**Quality / Patient Experience** - the Patient survey will show an improvement in patient experience when compared to a 19/20 baseline
7	**Staff Wellbeing / Optimum Capacity** - a process will be in place for supporting staff through any incidents
8	**Staff Wellbeing / Optimum Capacity** - Staff will be able to access coaching, counselling and emotional support through clearly defined routes and proactive input into staff emotional needs will be in place
9	**Quality / Staff Wellbeing / Optimum Capacity** - staff will be clear about what skills they should have for the specialisms they work in and managers will be able to plan skills development
10	**Staff Wellbeing / Optimum Capacity -** Divisional Managers will understand the impact of the WW&U Service
11	**Quality / Patient Experience / Staff Wellbeing / Optimum Capacity** - time and attention spent on activities and processes that do not require clinical skill will be reduced
12	**Quality / Access / Patient Experience / Staff Wellbeing / Optimum Capacity** - there will be an increase in applicants applying for Welsh Essential posts
13	**Staff Wellbeing / Optimum Capacity** - managers will demonstrate enhanced leadership qualities which will result in a reduction in grievances, disciplinary hearings etc. against a 19/20 baseline

PROGRAMME WORKSTREAMS		
Programme Reference	**Work stream**	**Description**
1	"Wellness, Work & Us" Service (WWU) + MH&LD Reflect and Learn Survey/BCU staff survey	Provide clarity about the services delivered and functioning of the WW&U Service over the next two years, and going forward. Understand the themes from the survey, capture you said, we did we are going to do themes and progress to actions
2	MH&LD Training & Development Group	Embed a cross-Divisional, multi-disciplinary approach to developing and agreeing skills development and provide clarity regarding mandatory training requirements
3	Recruitment & Development	Understand the journey of staff through the service and factors that impact on recruitment and retention, considering how the Reflect and Resolution policy can effectively support
4	Performance metrics	Establish KPI's, targets, metric's, monitor, review and reporting.
5	Establishment/Demand&Capacity Review	To complete Inpatient and Community service establishment review. Workforce Modelling

KEY RISKS TO DELIVERY (High risks only; for full risk details see programme risk log)	
Risk ID	**Description**
1	**Capacity for attending training** - staffing pressures may prevent attendance at training , workshops and meetings
2	**Unplanned costs for training** - unpredicted costs related to recruitment and training
3	**Pandemic / winter pressures response** - impact of Covid19 Pandemic and increased winter pressures may prevent staff from being released from their work areas
4	**Baseline information** - to establish KPIs may not be available and therefore may affect the ability to demonstrate tangible impact of interventions
5	**Capacity of programme team -** The capacity of the Workforce Work stream Group members
6	**Estates** - fit for purpose/capacity to enable new service recruitment
7	**Structure changes** - potential changes to MHLD Divisional structure may have an impact on the delivery

KEY ISSUES

Issue ID	Description	Likelihood	Consequence	Risk score	Mitigation	Residual Likelihood	Residual Consequence	Residual Risk Score	Owner	Open/ Closed
1	Capacity of leads? TBC							0		

HIGH LEVEL PLAN

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable Lead	RAG	Commentary

1. "Wellness, Work & Us" Service (WWU) - **Named Strategic Lead: Isabelle Hudgell**	6. Emotional Wellbeing support for staff & Staff Wellbeing	6.1	Set up / update working group to include the below actions:	Short Term	IH		
		6.2	To progress with Student counsellors to support MH&LD Counsellor, to enable continuation of counselling support and enable dedicated counselling support across the division, and to continue with the quantatitive and qualitative monitoring and reporting of the support provided		IH		
		6.3	Understand and describe the benefits and impact of implementing a Just Culture within the Division (SBAR)		IH		
		6.4	Senior leadership service visits		HOP's		
		6.5	Wellbeing sessions available to all staff		LM		
		6.6	Menopause support		IH		
		6.7	Review available Benefit packages and introduce additional staff benefits where feasible (Gym Membership, Financial Planning,Pension Advice, relationship Support)		IH		
		6.8	Review Child care support arrangements and assessthe feasibility of introducing support				
		6.9	Review Flexible working arrrangements and identify improvements to be implmented in line with staff requirements		?		
		6.10	Review current performance management / disciplinary processes and identify opportunities to improve the process within appropriate timescales		?		
	7. A manager's handbook will be available which describes key processes, systems and procedures	7.1	Consult with managers to identify workable solutions to support new leaders to engage in reflective solution-focused practise whilst developing emotional maturity and understanding	short term	IH/RJ		
		7.2	Create a working group to develop a manager's handbook (including newly appointed and experienced managers, 3rd year student, WW&U (links with Respect and Resolution Process?), Workforce)		IH/RJ		
		7.3	An outline of relevant sections to be included in Induction plan is drawn up and presented to the Divisional Workforce Group for agreement		IH/RJ		
		7.4	Include Checklist of staff performane cycle including 1-2-1s, mid-year reviews, appraisals etc to support line managers to appropriately manage staff		MF		
		7.5	Include checklist of available staff policies / code of conduct to support line managers in supporting their staff		RJ		
	8. Sickness theme analysis to reduce absences	8.1	Establish subgroup to develop and implement action plan to reduce absences based on presenting themes	short term	LM/MF/GC	On going	
		8.2	Review sickness rates by department and reason				
		8.3	Identify themes based on above				
		8.4	Review / develop return to work discussion process		LM/MF/GC	On going	
	13. Develop a comprehensive retention plan	13.1	Identify staff turnover rates		IH		
		13.2	Identify staff attrition by role, department, service area, age		WW&U		
		13.3	Review themes from exit interviews		WW&U		
		13.4	Identify and analyse themes		WW&U		
		14.5	Identify subgroup to develop and implement action plan based on themes to increase retention rates		WW&U		
	15. MH&LD Joint Partnership Group Meeting -	15.1	Terms of Reference drafted		CE	Completed	
		15.2	Kick off meeting completed		CE	Completed	
		15.3	Terms of Reference approved by Group		CE	Completed	
		15.4	Workforce plan approved by Group		CTH		

Work stream	Outcome	Plan Reference	Action	Target Date	Accountable	RAG	
	11. Gaps in training will be reviewed and a training plan for suicide awareness, WARRN and risk assessment training will be in place			Short Term	T & D Group	On going	
		11.1	Progress with WARRN training across the Division		RJ	On going	
		11.2	Roll out Risk Assessment scheme of HCA across the Division, which was piloted in Ty Llewelyn		RJ	On going	
		11.3	Progress with Suicide Awareness training course across the Division. Dates arranged for September and October 2022		RJ	On going	
		11.4	Convene training groups for service areas and identify clear training needs: Learning Disabilities SMS Forensic/Rehab Perinatal CHC Adult Inpatient MH Older Persons Inpatient MH Adult Community MH Older Persons Community MH Management		IH/HOPS	On going	
		11.5	Develop a training plan for all levels of the Division (and BCU where applicable) to move forward		T&D Group	On going	

2. MH&LD Training and Development Named Strategic Lead: Isabelle Hudgel and Robyn Jones	5. Coaching Programme implementation	5.1	Identify target audience for coaching eg. managers, staff in need etc	Medium Term	MF					
		5.2	Identify / articulate coaching programmes		MF					
		5.3	Clarify active coaches and their progress through training.		MF					
		5.4	Describe coaching activity across the Division		MF					
		5.5	Ensure a clear pathway is in place to receive and record coaching referrals		MF					
	10. Develop a skills & Competency framework	10.1	Identify roles that require a competency framework	Medium Term	IH/RJ					
		10.2	Map out the required skills and competencies required for those roles by engaging with relevant clinical governance channels		IH/RJ					
		10.3	Identify training requirements and available courses to achieve the required competencies		IH/RJ					
		10.4	Identify training plan for staff within those roles to be assessed and set timescales for staff to complete required training		IH/RJ					
	9. Career Pathway Development	9.1	Map out possible career pathway development for lower bands and A&C roles	Medium Term	IH/RJ					
		9.2	Identify available apprenticeship levy / funding		IH/RJ					
		9.3	Identify relevant training providers and courses to establish apprenticeship routes		IH/RJ					
		9.4	Identify support eg. functional skills to enable A&C and lower bandings to qualify for apprenticeship roles		IH/RJ					
		9.5	Develop apprenticeship policy and process detailing roles available within apprenticeship scheme		IH/RJ					
		9.6	Discuss / Further consideration for the career pathway of ANP post		IH/RJ					
		9.7	Discuss / scope further development of a career pathways for students		IH					
Work stream	**Outcome**	**Plan Reference**	**Action**	**Target Date**	**Accountable Lead**	**RAG**				
3. Recruitment & Development Named Strategic Lead: Claire Thomas-Hanna (TBC)	2b. Workforce Transformation	2b.1	Establish process / working group to redesign current workforce processes to increase capacity and identify new ways of working	**short term**						
		2b.2	Review current rostering arrangements and use of e-rostering to identify opportunities to ensure adequate service cover at all times							
		2b.3	Review current staff Bank process and identify opportunities to increase number of Bank staff and increase utilisation of Bank staff - scope possibility of joint staff Bank across the ICS							
		2b.4	Review opportunities to incentivise existing staff to cover additional shifts / join the Bank eg. part time staff; retirees etc							
		2b.5	Review Division application process and identify opportunities to streamline and enhance the process to reduce timescales and to attract more suitable candidates -review and revise application forms, asking relevant clear questions -review and articulate appropriate terms and conditions clearly in JDs eg. promote flexible working; training & development etc. -ensure language in JDs and PSs is inclusive to encourage applications from a diverse group of individuals -current HR support to issue offer letters, contracts, DBS and reference checks at pace							
		2b.6	Review equaities & diversity within the Division, reviewing WRES data, existing policies etc. to identify areas for improvement to ensure all staff groups feel included and report high satisfaction							
		2b.7	Review current use of volunteers and scope opportunities to increase / introduce volunteers							
		2b.8	Scope feasibility of enabling staff movement across the organisation / ICS to enable staff to move around at periods of high demand eg. digital staff passports							
		2b.9	Review staff communications across the Division and include relevant updates in existing bulletins to keep staff informed on priorities and plans to with a channel to enable them to provide feedback into plans							
		2b.10	Review staff work stations(including home working arrangements) to provide the necessary support to reduce the high level of absences as a result of back pain							
		2b.11	Update / Develop set templates to support managers to manage and have relevant conversations with their staff eg. 1:1s, mid year reviews, appraisal cycle, wellbeing conversation templates							
		2b.12	Produce a welcome pack for all new staff detailing good to know info about the organisation and division, who's who, code of conduct, policy check list, health & wellbeing offers, how to obtain advice etc.							
	3. Twelve month recruitment plan	3.1	Confirm budgeted establishment	**short term**	AJ	Completed				
		3.2	Determine gaps and identify vacancies		**GC/LM**					
		3.3	Break vacancies down by directorate, area, staff category, banding		**GC/LM**					
		3.4	Review service delivery priorities, incidents and areas of highest need		**GC/LM**					
		3.5	Produce recruitment plan in line with above factors prioritising areas with high vacancy rates and of high need with a focus on nursing, HCAs, A&C, Medical staffing		**CTH**					
		3.6	Obtain feedback from managers to include in plan		**CTH**					
		3.7	Obtain sign off from steering group		**CTH**					
		3.8	Obtain sign off from relevant organisation governance		**CTH**					
		3.9	Highligh in plan the need for all divisions to progress to timely recruitment		**AJ**					
		3.10	All areas to allocate recruitment to one dedicated lead to ensure vacancies progress timely. Current vacancy rate 150 wte, agree feasible vacancy rate		HOP's					

		3.11	Ensure MH&LD Divisional EC panel stood up every Monday as priority so all EC request discussed, agreed and approved timely	Short Term July2022	DSLT		
		3.12	Review and correct any budget errors impacting vacancy progress		HOP's.JG		
		3.13	Ensure all staff allocated to recruitment activities have the necessary access and skills for progressing vacancies at every stage of the process		HOP's		
		3.14	To include in local area Performance report compliance with Trac KPI;s to improve timeliness of recruitment		BSM's		
		3.15	Include in plan actions to reduce interims and fixed term posts		CTH		
		3.15a	Director of Operations to meet with each local area HOP and Finance to review current fixed term and seconded posts		CE		
		3.16	Progress with MH&LD Divisional proposed Operating Model.		DSLT		
	3a. Just R To deliver a 12 month, content led, digital campaign and marketing strategy to raise the profile of the opportunities in the MH&LD Division	3a.1	Create task and finish group with local area representative to ensure engagement and collaboration from across the Division.	Short Term July 2022	AJ		
		3a.2	Agree key milestones and deliverable of the marketing campaign, including the provision of weekly dashboard reporting		AJ		
		3a.3	Plan virtual and face to face recruitment events		AJ		
		3a.4	Progress with creation of digital campaign including creation of video, flyers, posters, photos, testimonials etc.		IH		
		3a.5	Review and agree governance process		CTH		
		3a.6	Agree performance reporting (KPI's) and review on a frequent and regular basis		AJ/CL		
	4. All welsh essential roles	4.1	Develop action plan for up to date, bilingual, appropriate JD's and PS's for every role across the Division which are stored in the BCUHB Job Library	short term	AJ		
		4.2	Ensure there are appropriate bilingual JDs and PSs for every role across the in the BCUHB Job Library		AJ		
		4.3	Ensure JDs and PSs for Welsh essential posts are not in breach of Welsh Language criteria		AJ		
		4.4	Ensure all JDs have appropriate CAEJ number, verified by the Job Evaluation team		AJ		
		4.5	For Welsh Essential posts insure Welsh speaker included on Interview panel, and one question asked in Welsh to ascertain the level of welsh accomplishment		AJ		
5. 'Staffing Establishment' review Named Strategic Lead: Adrian Jones, ADON	5. Develop 'whole system' Demand and Capacity model (establishment review completed for inpatient -> capacity next)	5.1	Review 'North Wales Population Health Needs Assessment (2022)' + identify population health drivers (projected population increase/decrease by age group and area)	30/07/2022	AdJ		
			Complete 'Demand and Capacity analysis' for each service (inputs, activities, caseload / staffing / beds, outputs) + repeat referrals / attendances / admissions	30/08/2022	AdJ		
			Complete referral / admission 'deep dive' for each service e.g. referrer, referrer type, referral reason etc	30/09/2022	AdJ		
			Complete repeat referral (primary/community) / presentation (ED) / admission 'deep dive' analysis for each service	30/09/2022	AdJ		
			Develop 'whole system D&C model' with agregated service information	15/10/2022	AdJ		
	Scope staffing competencies, develop 'evidence based skill matrix', gap analysis and recommendations	5.2	Review 'qualifications / competencies' for all staff in each service (HR records / staff survey)	30/10/2022	IH		
			Review evidence base of 'What Works For Whom' by primary presenting reason / diagnosis + develop evidence based skills matrix	30/10/2022	IH/AdJ		
			Complete staffing/skillset 'gap analysis' based on current + projected D&C + updated recommendations to inform training + recruitment strategy	30/11/2022	IH/AdJ		
6. Link into Estate's Leads	Include Estates Leads in workforce programmes	6	Understand the available Estate from which services are deivered Understand the impact of estate constraints on staff delivery of services Link estates leads into workforce plans in line with available estate	30/11/2022	CL/KH		

Medium Priority 12 Months

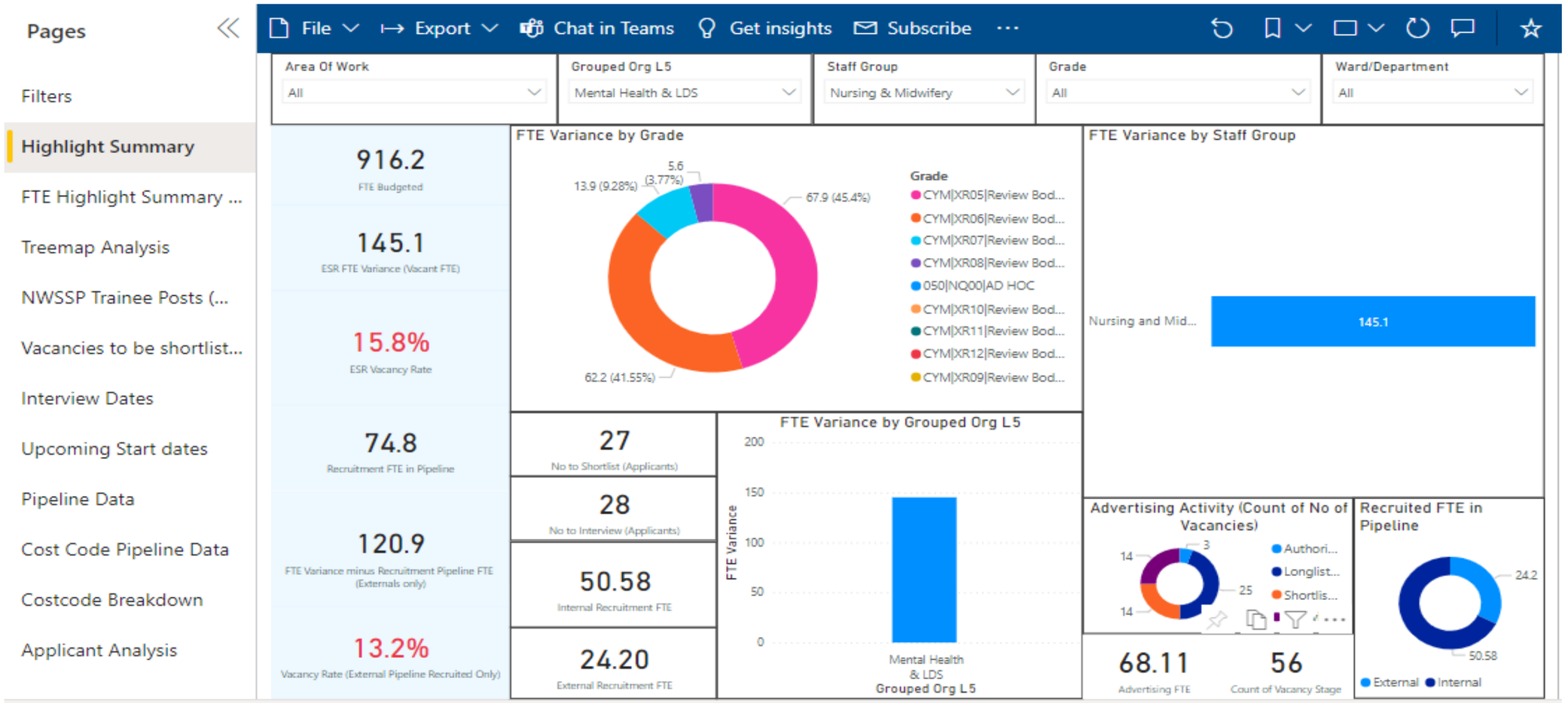
Work stream	Outcome	Plan Reference	Action	Target Date	Accountable	RAG	
1. "Wellness, Work & Us" Service (WWU) - Named Strategic Lead: Isabelle Hudgell	18. TRIMM Support following incidents	18.1	Review Division incident logs	Short term	IH/Gov		
		18.2	Identify areas of support		WW&U		
		18.3	Liaise with TRIM to commission relevant support		IH/Safeguarding		
		18.4	Progress with the TRiM SBAR (2 day training) proposing the training of 8 MH&LD staff to enable timely and local support to staff post incidents		IH	Completed	
		18.5	Obtain relevant sign off		IH		
	20. New starter Questionnaire / exit interview questionnaire	20.1	Review / develop new starter questionnaire	Medium Term	WW&U	Completed	
		20.2	Review / develop exit questionnaire		WW&U	Completed	
		20.3	Analyse and identify themes		WW&U		
		20.4	Share themes with workforce group and identify actions to be taken forward		IH		
		20.5	Dependent upon required actions, establish subgroup		IH		
	21. Reflect & Learn Survery	21.1	Review, Reflect & learn themes and feedback to all staff in the form of 'You said, we did!'		IH		
	22. A WW&U Betsinet page will link into the BCU Wellbeing page	22.1	Ensure WW&U is represented on Betsinet Wellbeing pages		LO		
		22.2	Review Reflect & Learn themes and feedback to all staff in the form of 'You Said. We Did..."		IH		
		22.3	Review the actions aligned to the BCUHB Staff Survey to ensure local area action plans are developed to progress.		LO		
Work stream	**Outcome**	**Plan Reference**	**Action**	**Target Date**	**Accountable**	**RAG**	
		17.1	Create sub-group of the 'Training & Development Group' to review available Leadership and Management training opportunities		FE/IH		

2. Training and Development **Named Strategic Lead: Isabelle Hudgell**	17. Leadership Development Opportunities	17.2	Describe essential skills development for Divisional Leaders and represent in the Guidebook (which guide book?)	Medium Term	IH		
		17.3	Identify, describe and disseminate to all staff further development opportunities for enhancing leadership skills		IH		
		17.4	Identify training approach (self teaching, tutorial, seminar? etc),		IH		
	19. Student Feedback on placements	19.1	Identify departments that have had student placements	Medium Term	IH		
		19.2	Develop student survey and ensure all students are provided with a copy of the survey to complete		IH		
		19.3	Analyse survey and collate themes from responses		IH		
		19.4	Share with workforce group		IH		
		19.5	Develop and implement plan to improve student experience to encourage students to take up roles within the division		IH		
	16. MH&LD Staff Induction booklet	16.1	An outline of relevant sections to be included in Induction plan is drawn up and presented to the Divisional Workforce Group for agreement		WW&U		
		16.2	Exit Interview and New Entry Questionnaire collating information to enhance learning staff experiences, retrospective from last 12 months		WW&U		
		16.3	To continue to progress indicatives, plans and progress with the MH&LD Joint Partnership group to ensure engagement, awareness, collaboration is held with staff side representative.		WW&U		
		16.4	Produce comprehensive Induction checklst for managers and new starters		WW&U		
		16.5	Identify process to obtain Badges, access pass, uniform etc.		WW&U		

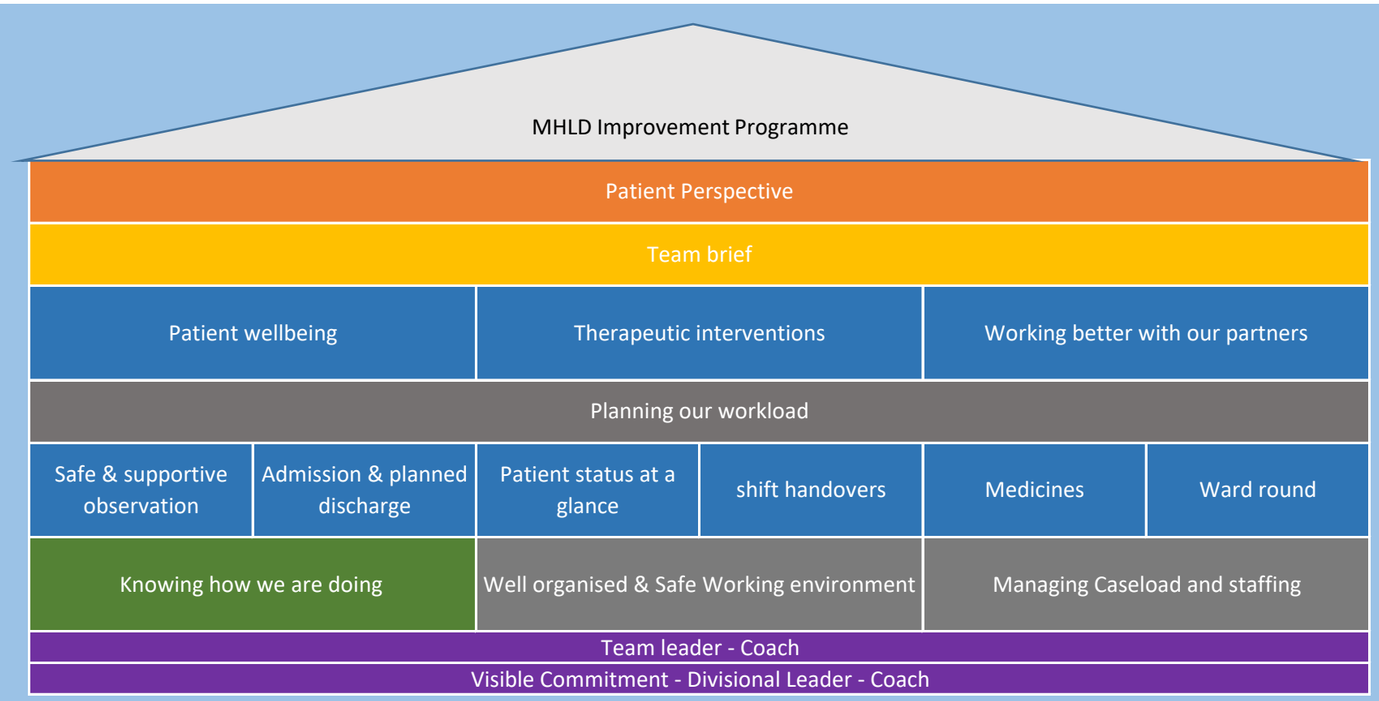
KEY PERFORMANCE INDICATORS -

Metric Ref	Metric	Data Source	Incremental improvement trajectory - Go Live Septement 2022							Commentary
			Data @ 30/7/2021	Data as @ 30/04/2022	Baseline as @ 31/08/2022	2 months @31/10/2022	4 months @31/12/2022	6 months @28/02/2023	8 months @30/04/2023	
1	Number of Nursing vacancies as % of wte - showing a month by month reduction trend	Vacancy report	125.93WTE/ 43.65%	141.35WTE/ 43.41%						
	Number of HCA vacancies as a% of wte) - showing month by month reduction trend	Vacancy report	15.89%	17.54%						
	Number of Admina & Clerical vacancies as a % of wte) - showing a month by month reduction trend	Vacancy report	15.34%	11.16%						
	Number of Medical vacancies as a % of wte - showing a month by month reduction trend	Vacancy report	16.74%	15.38%						
2	Average number of applicants for Nursing posts internal/external.	Vacancy report	0.9	2						
	Average number of applicants for HCA internal/external	Vacancy report	3.5	4.4						
	Average number of applicants for A&C internal/external	Vacancy report	1.1	1.6						
	Average number of applicants for Medical internal/external	Vacancy report								
4	Of the candidates who applied ,% how many came from Just R	Power BI Dashboard								
5	No. from Just R digital campaign recruited to nursing posts ? (Consider Shortlisting rate for Trac applicants/candidate criteria?)	Just R								
	No. from Just R digital campaign recruited HCA posts (Consider Shortlisting rate for Trac applicants?)	Just R								
	No. from Just R digital campaign to recruited Admin and clerical posts (Consider Shortlisting rate for Trac applicants?)	Just R								
	No. from Just R digital campaign to recruited Medical posts (Consider Shortlisting rate for Trac applicants?)	Just R								
6	Success rate Nursing showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate HCA showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate Admin and Clerical showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
	Success rate Medical showing improvement trend (shows the value of the campaign)	Power BI Dashboard								
7	EC portal process - time taken for each approval stage?	LM								
8	TRAC KPI DATA Notice Date to Authorisation Start Date - % completed within time frame of 5 days	Power BI Dashboard								
9	TRAC KPI DATA Time to Approve Vacancy Request - % completed within timeframe of 10 days	Power BI Dashboard								
10	TRAC KPI DATA Time to Shortlist - % completed within timeframe of 3 days	Power BI Dashboard								

11	TRAC KPI DATA Time to Update Interview Outcomes - % completed within time frame of 3 days	Power BI Dashboard									
12	TRAC KPI DATA Time to Approve References - % completed within time frame of 2 days	Power BI Dashboard									
13	TRAC KPI DATA - Vacancy Creation to Conditional Offer - % completed within time frame of 44 days	Power BI Dashboard									
14	Geographical location of applicants - top 5 - split for staff groups	Power BI Dashboard									
16	Source of Applicants - top 5 - split for staff groups.	Power BI Dashboard									
19	Increase Number of Exit Interviews completed, target 100% completion.	WOD			Data?						
20	% Sickness rate across the MHLD - reduction trend (comparative against other areas in BCU)	ESR - staff absence report Jun '21 - May '22			**9.45 %**	8.45% April & may '22					
22	Overtime spend - planned reduction	Finance report									
23	Agency spend - planned reduction	Finance report									
24	Bank spend - planned reduction	Finance report									
26	Improve completion of Supervision for all staff groups from 2087 per year to 8000 per year	ESR			**693** **(3,036 for year)**						
27	Improve PADR achievement from 71.9% to 85%	ESR			**80.90%**						
28	Improve Mandatory Training achievement from 78.8% Target 85%	ESR			**78.00%**						
29	No of staff attending Suicide awareness (no. / % of clinical staff) (check with MS/AJ if any other key training to also include)	T & D group									
30	No of staff attending WARRN training (no. / % of clinical staff)	T & D group									



Example Power BI Dashboard



Key:

- S1: Fundamentals of Care
- S2: Leadership, empowerment, culture & OD
- S3: Safe & Effective Care
- S4: Individual & Timely Care
- S5: Environment & Resource
- S6: Audit, outcomes & assurance

House

MENTAL HEALTH & LEARNING DISABILITIES DIVISIONAL IMPROVEMENT PLAN

The Divisional Improvement plan represents the portfolio of work streams that are being undertaken across the Division and includes Service developments, Operational improvement, and Service Transformation. These work streams include initiatives to enhance people, organisational development, culture-based improvements, and safety.

Timescales - development, colloboration and implementation of the Improvement plan

House - visually showing the foundations of improvement

Tier 1 - Workstreams identified following a triangulation and thematic analysis exercise.

Teir 2 - Sub Themes developed aligned to improvements, including links to specific internal and external reports, inspections and incidents.

Tier 3 - Task Level Detial to inlcude Immediate assurance actions, Improvement actions and Assurance actions

Key Performance Indicators - high level indication showing how the Division will evidence improvement

Power BI Dashboard - data capture for evidence of improvement

HSE NOC Action Plan - update aligned to HSE NOC, including progress made

Plan on a Page examples incorporating Aims, Objectives, Benefits and Outcome of each Workstream

Phases

TIER 4: PHASED IMPLEMENTATION OF IMPROVEMENTS - HI LEVEL GANTT

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

Key:
- In progress
- Complete
- Not yet started

	Week beginning	20-Jun-22	27-Jun-22	04-Jul-22	11-Jul-22	18-Jul-22	25-Jul-22	01-Aug-22	08-Aug-22	15-Aug-22	22-Aug-22	29-Aug-22	05-Sep-22	12-Sep-22	19-Sep-22	26-Sep-22	03-Oct-22	10-Oct-22	17-Oct-22
	Week Number	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*18*
Preparatory phase	Agree scope & main workstreams																		
	Commit to Programme methodology and taxonomy			Completed															
	SRO agreed			Completed															
	Programme Director appointed																		
	Committed additional programme support																		
	workstream leads agreed with dedicated time																		
	sub-streams agreed																		
	sub-streams PIDs in place																		
Stream 1	Workstream 1: Fundamentals of Care																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 2	Workstream 2: Leadership, empowerment, culture and OD																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 3	Workstream 3: Safe Care & Effective Care																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 4	Workstream 4: Individual & Timely Care																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 5	Workstream 5: Environment & Resource																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		
Stream 6	Workstream 6: Audit, outcomes & assurance																		
	Structured programme of work underpinning each sub stream PID																		
	Populated Gantt to reflect sub-stream components																		
	Programme fully underway																		

Phases

Tier 1: MHLD Improvement Plan **Workstreams**

Rationale: These workstreams were identified following a triangulation and thematic analysis exercise. They draw upon the categories within Healthcare Standards, in keeping with standards used by HIW, as well as interface constructively with the existing pan-BCU improvement programmes.

Workstream 1:	**Fundamentals of Care**
	Areas that are fundamental to the delivery of safe care and an excellent patient experience
Workstream 2:	**Leadership, Empowerment, Culture and OD**
	Compassionate leadership, team working
Workstream 3:	**Safe Care & Effective Care**
	Quality and evidence based person centered care
Workstream 4:	**Individual & Timely Care**
	Right care, right time and right place
Workstream 5:	**Environment, Resource & Workforce**
	Includes staffing capacity and safe spaces
Workstream 6:	**Clinical Strategy, Audit, Outcomes & Assurance**
	Good governance, Clinical Strategy, Model of Care and Operating Model development

Tier 2: MHLD Improvement Plan **workstream sub-themes**

			HSE NOC	YGC Plan	Crisis Care recommend.	Ockenden	HASCAS	Community Suicide, HB	Psych. Therap. Review	HIW Inspections - Heddfan, Hergest, Coed Celyn, Mesen	Primary Care Dischardge MH review	Ablett Inpatient Suspected Suicide	Hergest Suspected Inpatient Suicide, DO	Ty Llywelyn unexpected Death	Holden	HSE Notice: Falls	Psychiatric Liaison review	OD review Mike Shaw	Targetted Intervention	IMTP
S1: Fundamentals of Care		**Named Lead: HoN**																		
1.1	Comprehensive understanding of roles & responsibilities	Head of Workforce	1	1		1											1			
1.2	Improve record keeping in line with BCUHB policy/procedure and national guidance	Quality and Safety Lead	1	1			1			1				1			1			
1.3	Review Inpatient/ward based care processes	Clinical Operational Manager	1	1	1									1	1				1	1
1.4	Improve the delivery of care to patients with Dementia	Dementia Consultant			1	1													1	
1.5	Improve the delivery of crisis care, including psychiatric liaison	Head of Governance		1	1	1											1		1	
S2: Leadership, Empowerment, Culture and OD		**Named Lead: Head of Workforce**																		
2.1	Strengthen sustainability & stability of leadership roles	Head of Workforce		1		1			1	1									1	
2.2	Increasing leadership visibility	Director of Operations		1		1				1					1					
2.3	Develop an open and honest culture where staff feel empowered	Wellness, Work and Us Lead	1	1					1	1					1			1	1	
2.4	Strengthen cohesive, multi disciplinary team working	Clinical Director, Central	1	1		1			1									1		
2.5	Strengthen communication & engagement with staff and partners	Communications officer		1		1			1	1									1	
S3: Safe & Effective Care		**Named Lead: HoN**																		
3.1	Improve & strengthen the management of risk across the Division	Head of Governance (FM)	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3.2	Reducing the risk of ligature incidents	Head of Governance (GK)	1							1			1	1						
3.3	Ensure all observations are at the appropriate level to ensure they are safe and therapeutic	Head of Governance (GK)	1									1	1	1						
3.4	Reduction of incidents in relation to falls, medication errors and the deteriorating patient	Quality and Safety Lead	1			1				1				1	1		1	1		
3.5	Improving the recognition of safeguarding adults at risk and ensuring the appropriate pathway is followed	Safeguarding Lead	1			1									1					
S4: Individual & Timely Care		**Named Lead: Ops Lead**																		
4.1	Right care at the right time in the right place	Head of Nursing	1	1	1				1	1		1					1		1	
4.2	Review of current service processes	Head of Nursing	1	1	1							1					1		1	1
4.3	Individualised Care planning to promote independance	Head of Nursing			1										1				1	
4.4	Admission, Discharge and management of leave	Head of Nursing	1	1	1					1		1							1	
4.5	Listening and learning from patient & carers/family feedback	Quality and Safety Lead			1	1													1	1
4.6	Patient, carer and family information	Quality and Safety Lead			1				1	1									1	
S5: Environment and resource including workforce capacity and capability		**Named Lead: Planning Lead**																		
5.1	Roles capability - skills, knowledge & practice	Head of Workforce		1						1				1					1	
5.2	Managing daily caseload and staffing incl. rostering	Head of Planning and Performance		1						1									1	
5.3	Well organised and safe working environment incl dignity ie privacy	Assistant Director of Nursing	1	1	1	1				1							1			1
S6: Audit, Outcomes and Assurance		**Named Lead: Governance Lead**																		
6.1	Governance, risk and course correction (learning)	Head of Governance	1	1		1	1					1		1			1		1	
6.2	Knowing how I am doing - continuous audit cycle plan	Head of Governance		1						1				1						
6.3	Clinical policies and standard operating procedures	Quality and Safety Lead	1	1		1	1	1	1	1			1	1	1	1	1	1		
6.4	Strategy development	Medical Director																		

Tier 3: MHLD Improvement Plan **task level detail**

S1: Fundamentals of Care (Strategic Lead - HoN / HoG)		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Head of Nursing**
1.1	All staff have a comprehensive understanding of their roles & responsibilities	Problem: actions demonstrate that staff can be unclear as to their role, responsibility and accountability resulting in a lack of decision making and suboptimal risk formulation, risk management and	Actions	Outcome	Supervision levels. Baseline from previous full years Supervision records. Percentage of staff that report that their manager takes a positive interest in their Health and Wellbeing - MHLD Div Performance Report	RAG rating	Programme Phase	Start date	Complettion date	Head of Workforce
1.1.1	Ensure all staff have an understanding of their roles and responsibilities	At all levels of the organisation, staff are not fully aware of their role in the management of risk.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements **Improvement actions:** • CAEJ referenced job descriptions in place for each role with the creation of a MH&LD Divisional Job Description Library • Develop team objective templates that can be populated by each team to enable staff to ensure they understand their roles and responsibilities • Establish reflective practice groups to enable staff to meet and reflect on activity and discuss next step priorities • Develop an induction pack and process for each staff group so all new staff undergo consistent standardised induction, including requirements of their role • Improve consistency of individual / group Supervision sessions with line manager including monthly team meetings • Expedite the review all of Div. policy and procedures to ensure reviewed on time, full consultation occurs and updated when lessons learnt (refer to section 6) **Assurance actions:** • Annual audit of management evidence procedures to include PADR documentation • Managers will provide written confirmation to ensure that the PADR process & supervision take place according to Div. policy (refer to workforce Plan on a Page) • Sampling of notes and care plans and unannounced visits	All staff will have a clear understanding of their roles and responsibilities	% compliance for all complete Level 1 competencies of Core Skills & Training Framework - Quarterly NHS Framework report PADR compliance and supervision measured and reported monthly (via ESR) : quality checking of PADR/supervision Link to KPI PADR compliance		Phase 1	Aug-22	Jan-23	Head of Workforce
1.1.2	Improve the quality of supervision & PADR	Staff are not comfortable in speaking up and challenging decisions. This can impact on clinical safety, efficiency and clinical outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements • Review and strengthen the connection of team objectives to PADR **Improvement actions:** • Training plan to be implemented to embed policy for supervision & PADR completion • Develop consistent PADR management guidance to support managers • Review available PADR training for supervisors and revise accordingly to increase attendance. Explore new model of Group PADR. • Increase PADR compliance to 85% across all areas, monitor and review in MH&LD Finance and Performance meeting **Assurance actions:** • Review success of current PADR process and obtain staff feedback to revise	All staff feel confident to speak up when clinically appropriate to do so	Percentage improvement in completion of PADR and Supervision. PADR/supervision audited quarterly against agreed standards e.g. BCUHB values, roles and responsibility. Percentage count of who has had a PADR/medical appraisal in previous 12 months - NHS Performance Framework		Phase 1	Jun-22	Jan-23	Head of Workforce
1.1.3	Improve discharge through full implementation of discharge policy	Specific examples of incorrect discharge of patients from primary care mental health services due to incomplete risk assessment	**Immediate assurance actions:** • **DTOC workng group established, including weekly reporting.** • Review the MHLD Division governance structures, including how area mental health teams work together as one service, to ensure common understanding, and service delivery processes • Review all Datix entries relating to Primary Care Mental Health patients, as further evidence as to whether any patient harm was caused **Improvement actions:** • Refresh and improve the communication processes in the division to better support a two way flow of information, ideas, suggestions and decision making between the directors and the operational area mental health teams • Strenghen and support Listening Lead model • Agree and adopt common terminology for primary care and community mental health services across the MHLD division, Health Board and key stakeholders • Ensure a clear definition of roles and responsibilities across primary care and community mental health services, with consideration as to the need for consistent management structures and roles across the area mental health teams • Develop engagement processes and joint working across the MHLD division, ensuring a better understanding of decision making and accountabilities • Improve collaborative working between the MHLD division and clusters, with local area mental health teams sharing their current practice and suggestions • Review the Part 1 MHM model of care in North Wales, to include engagement with the three Area Divisions, clusters and other key stakeholders • Undertake an option appraisal of interim improvements to IT system support for the MHLD division, whilst awaiting the roll out of Welsh Community Care Information System (WCCIS). **Assurance actions:** • Annual report to Board to provide assurance of completion of actions and improvemnts • Sampling of notes and care plans and unannounced visits	All patients discharged have a comprehensive risk assessment and discharge plan completed and approved	Number of safety incidents relating to Discharge - Baseline over previous 12 months from ESR reporting target improvement to be set.		Phase 1	Aug-22	Mar-23	Head of Workforce

1.2	Improve record keeping in line with BCUHB policy/procedure and national guidance e.g. Mental Health Measure & Mental Health Act	Problem: Inaccurate, incomplete and missing documentation/records that impacts on continuity of patient care, decision making and patient	Actions	Outcomes	Supervision levels - Baseline from previous years Supervision records.	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
1.2.1	Implement MH&LD dissemination and improvement plan for record keeping and documentation	Clinical records are not consistently complete. Risks for patients result when clinical records are not complete, accurate, person-centred and updated.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements • Ensure all staff have access to the Health Records policy, proceudures and guidance and both are available in all staff areas **Improvement actions:** • BCUHB Record Keeping Policies and procedures will be shared, signed and to confirm these are understood by all staff and discussed at supervision (supervision document to be revisited and renewed) • Ensure record keeping is included within staff inductions • Record keeping training to be included in training plans, to be carried out by Health Records manager • Established audit cycle of records to ensure compliance and that staff continue to improve and maintain accurate records • Review a sample of Supervision records to ensure Managers have quality assured a sample of case notes with staff to rectify any anomalies during thier Supervision **Assurance actions:** • Annual service led deep dive review into the quality of clinical records / sampling of notes and care plans and	All clinical records are complete, with care plan and quality assured, by a manager	Documentation checks and validation. If baseline does not exist, establish a target completion % and measure Weekly. 95% of all staff have received policy & procedure and confirmed understanding by sign off and within supervision*this is to provide some t		Phase 1	Aug-22	Jan-23	Quality and Safety Lead

1.2.2	Ensure the design and implementation of a rolling records audit for MH&LD	Audits have not been consistent to pick up the quality and completeness of clinical records.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements **Improvement actions:** • See actions for 1.2.1 **Assurance actions:** • Develop an Audit plan to cover all areas of the division, and all professions, running on a continual, cyclical basis • Sampling of notes and care plans and unannounced visits	All clinical records are complete, with care plan and quality assured by a manager	Audit programme up and running by end of December, to cover all areas by January 2023		Phase 1	Aug-22	Oct-22	Quality and Safety Lead
1.2.3	Restructure and redesign its hard copy clinical records archiving and retrieval systems	Significant issues with care documentation have been identified, which included the following: a. Risks had been identified, but no care plan was in place to address the risk. b. Evaluation of section 17 leave not always documented. c. Issues with a lack of care plans for noncompliance of medication.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvements - this will not need to be done as HR Group meeting underway • Alignment with Estates and Facilities management to assess **Improvement actions:** • Progress with Health Records subgroup aims, objectives and actions • Review current clinical record system including process from inception to archive • Identify areas to improve and redesign clinical records • Review current supplier arrangements (TATA, Oasis) to support the storing and archiving of records and procurement options as required **Assurance actions:** • Annual review / Sampling of notes and care plans and unannounced visits	All clinical records are complete, with care plan and quality assured by a manager	Monthly spot audits of record storage - results to inform improvements in record storage and retrieval - Baseline generated from previous audit outcomes.		Phase 1	Jun-23	Oct-22	Quality and Safety Lead

1.3	Review inpatient/ward based care processes e.g. ward rounds, shift handovers, Patient Status At a Glance * *not specific to any recommendation but good practice to review*	Problem: Understanding the current position and identification of any improvements required	Actions	Outcomes	Patient length of stay reduction - baseline from agreed 12 month records. Reduction in the no. of patients delayed discharge - Baseline from 12 month patient records.	RAG rating	Programme Phase	Start date	Complettion date	Clinical Operational Manager
1.3.1	Improve handovers and transfers of care to aid better communication between staff and external agencies	When the team meets for handover, inadequate time is allocated to discuss patients' needs, risks and management plans.	**Immediate assurance actions:** • Rapid review of root cause analysis (completed with 3rd parties) to understand the problem **Improvement actions:** • Review current 'safety huddle model' to communicate key safety information between healthcare professionals • Review / establish handover notes template to ensure that all patient concerns are clearly documented to aid a seamless handover • Review Putting Things Right (PTR) process for reviewing incidents and areas of concern that require improvements and ensure staff are up to date and compliant in those areas • Ensure the relevant operational procedures, protocols and processes are updated and that all staff have easy access to them (see section 6) • Strengthen staff and patient feedback to continually improve processes/actions completed (Caniad) • Establish a Team meeting Agenda to ensure ward processes are discussed to maintain awareness and continually improve **Assurance actions:** • Annual pathway audit / co-review with patients and carers • Sampling of notes and care plans and unannounced visits	All handover meetings will be completed with sufficient time to review holistic patient needs, risks and ensure a management plan is agreed.	Reduction in patient length of stay; reduction in no. of delayed discharges; handover review (see sub stream 1.2.3) - Baseline from previous 12 months patient records.		Phase 1	Aug-22	Dec-22	Clinical Operational Manager

1.4	Improve the delivery of care to patients with Dementia	Problem: Dementia: delivery of clinically led, safe and effective	Actions	Outcomes		RAG rating	Programme Phase	Start date	Complettion date	Dementia Consultant
1.4.1	Implement the review, redesign and development of a new 'end to end care pathway' for Older People and those with Dementia across the six counties of North Wales (including wellbeing and mental health)	Older People's mental health services have an incomplete skill set in relation to the care of patients with dementia and the support of their families	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Ensure that the patient area is underpinned by dementia-friendly design principles and safety assessed and free from hazardous materials to prevent any injuries e.g. falls • Obtain feedback from patients and their families and use the feedback to improve service provision **Improvement actions:** • Identify leads across the six counties to undertake review of services supported by Cons Nurse Dementia • Review internal Memory Service review by clinical nurse - Sep/Oct 22 • Review Memory Sevice review document by consultancy - Sep/Oct 22 • Review of dementia practices and their evidence base • Gap analysis of skills/knowledge/attitides required and 'current state analysis' to be completed • Gap analysis of skills required and current position to be completed • Implementation of pathway redesign project (just started 08.22) - 6 mnths • Ensure relevant staff are aware of and have easy access to the service dementia strategy and relevant guidance (align to North Wales Dementia Strategy) • Continue to raise dementia awareness and what can be done to manage the condition and to signpost to available support offers • Increase/enhance Memory service provision aligned to transformational programme, including options for remote assessments • Ensure relevant staff are aware of and have easy access to dementia strategy/policy/guidance (align to North Wales Dementia Strategy) • Current and forward looking workforce and service plans for the provision of appropriate levels of therapy and non-medical care for people with dementia • Ensure that the patient's needs are identified and clearly documented in an individualised care plan • Implement recommendations for transforming OPMH crisis support • Embedding of strong co-production, engagement and communication with patient groups through development of Division engagement model **Assurance actions:**	All patients will participate in high quality advice and support within mandatory timescales, in the right place, in the right way and at the right time.	Improved referral to assessment (average time) / reduced waiting list, improved patient experience, improve caseload : clinician ratio, improved contact : clinician ratio, improved clinical outcomes, reduced average cost per visit, reduced average annual		Phase 1 & Phase 2	Aug-22	Jul-23	Dementia Consultant

1.5	Improve the delivery of Crisis Care including psychiatric liaison	Problem:	Actions	Outcomes	Metrics developed following the Good Work - Dementia Learning & Development Framework - QSE Agenda	RAG rating	Programme Phase	Start date	Complettion date	Psychiatric Liaison Manager

1.5.1	Complete the review, redesign and development of a new 'end to end pathway' for psychiatric liaison services across the six counties of North Wales	Fragmented system of support without explicit North Wales Model of Care	**Immediate assurance actions:** • Rapid review of root cause analysis to inform immediate assurance actions **Improvement actions:** • Full implementation of the crisis support improvement programme (see plan on a page) • Full implementation of psychiatric liaison report (2022) recommendations **Assurance actions:** • Annual audit / spot checks with patients • Sampling of notes and care plans and unannounced visits	All patients will participate in high quality, responsive crisis care, within mandatory timescales, wherever they are based, according to best practice.	Improved referral to assessment (average time) / reduced waiting list, improved patient experience, improve caseload : clinician ratio, improved contact : clinician ratio, improved clinical outcomes, reduced average cost per visit, reduced average annual cost per patient - Baselines to be generated from any 12 month data. **TO BE AMENDED**		Phase 1 & Phase 2	Aug-22	Jul-23	Psychiatric Liaison Manager

S2: Leadership, Empowerment, Culture and OD (Stra		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Head of Workforce**
2.1	Strengthen sustainability & stability of leadership roles throughout division	Problem: lack of sustained stability within leadership roles across the Division resulting in staff dissatisfaction and variation in care strategy and delivery, which impacts on patient outcomes and experience	Actions	Outcomes	Starters/Leavers data - Baseline for previous 12 months. Percentage increase in positive Service User Experience feedback measured through service user feedback platforms; inclusive of Targeted Intervention Outcome 3 evidence submission	RAG rating	Programme Phase	Start date	Complettion date	Head of Workforce
2.1.1.	Ensure that Senior Leadership roles are appointed to	There is insufficient strategic and improvement capacity to drive change in the Division.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Undertake a gap analysis to identify limitations in leadership capacity to drive change and improvements across the Division • Complete appointment of all interim roles • Recruit interim MH&LD Estates Lead for 12 months minimum **Improvement actions:** • Agree and implement Operating Model • Full review of all interim roles, progress with substansive posts as approrpriate • Establish relevant posts in line with budget and EC panel processes • Develop clear, relevant job descriptions and person specifications • Progress with Just R 12 month recruitment campaign (Go Live date September 22) aim to appoint 14 staff per month. • Complete recruitment to Service Improvement Team (8 posts) **Assurance actions:** • Annual establishment and staff survey engagement review	All senior roles will be appointed to in year 1.	No. of Senior Leadership Roles vacant - baseline number to be established to determine % complete		Phase 1 & Phase 2	Jul-22	Dec-23	Head of Workforce
2.1.2	Development and implementation of the Leadership & management developmental strategy	Staff feel they are not consistently communicated with compassionately by senior leadership.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities Improvement actions: • Progress with Wellness, Work and Us Year 2 Service Delivery Plan • Undertake a Training Needs Analysis • Development of career pathways • Development of an Apprenticeship framework • Action plans from BCU Staff Survey • You said, We did, We are going to do from MH&LD Reflect and Learn survey • Create a coaching programme for all senior leaders by utilising the newly appointed work based coach for the division? • Identify leadership training requirements • Commission leadership training for effective leadership and improved culture • Ensure clear documented team / Division goals and objectives that leaders can aspire to, with development of Manager Handbook • Establish a mentoring system to support the development of new leaders in post • Establish leadership forums to ensure leaders are aware of the desired culture and have the capability to inspire and drive organisational culture • Engagement with BCUHB wide clinical leadership and management scheme; • Implementation of workforce development plan **Band 6** and above clinical/operational and business support to have completed a Training Needs Analysis to determine level of awareness **Assurance actions:**	All staff feel confident to speak up when clinically appropriate to do so	Clinical Leaders Listening Time - Monthly reporting, baseline from previous 12 months, target to be agreed.		Phase 1	Jul-22	Jan-23	Head of Workforce
2.1.3	Complete the robust implementation of a consistent and high quality PADR process for all staff	Staff do not feel fully supported to develop into leadership roles within the Division.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Every member of staff to have an up-to-date PADR aligned with strategic objectives and BCUHB values. • Monitor improvement in PADR compliance so all staff have received their PADRs • Review Digital solutions for Div PADR (where paper based) as contingency due to delays in All Wales WCCS IT solution **Assurance actions:** • Annual audit / completeness and quality	All staff feel supported with their career development needs and aspirations	Percentage headcount who have had a PADR/medical appraisal in the previous 12 months - NHS Performance Framework (95% of all staff to have up to date PADRs - captured via ESR **this is to provide some tolerance within the system for PADRs not completed within the timeframe due to such things as long term sickness, unexpected absence etc.)*		Phase 1	Aug-22	Jan-23	Head of Workforce

2.2	Increasing leadership visibility, at all levels, with a purpose	Problem: Staff felt that leaders (local and divisional) were less visible impacting on staff feeling less valued (decision making, listened to)	Actions	Outcome	Increase in service user positive experience and satisfaction vie service user feedback; Overall staff Engagement - NHS Performance Framework monthly reporting,	RAG rating	Programme Phase	Start date	Complettion date	Director of Operations
2.2.1	Ensure there is Visible leadership with regular visits to site and clinical areas	Staff see Senior Leadership infrequently and want their issues to be seen and heard with additional support	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Meet with staff to understand the root cause of their concerns Share these findings with Operations Managers & DSLT and agree what realistically can be delivered so staff expectations can be managed • Develop plan for team development days, staff engagement sessions, service meeting participation • Include pen portraits into MH&LD Staff Briefing for all Directors and Senior Leads across the Divison **Assurance actions:** • Bi-annual audit of leadership visits	All leadership staff meet with clinical teams on a monthly basis	Percentage of staff that report that their line manager takes a positive interest in their health and well being - Divisional Performance Report Monthly- Baseline from previous 12 months. "You said, we did" feedback to staff provided on a monthly ba		Phase 1	Aug-22	Jan-23	Director of Operations

2.3	Develop an open and honest culture where staff feel empowered	Problem: not all staff feel confident to raise concerns, challenge decisions and make decisions autonomously within their scope of practice	Actions	Outcome	Increase staff satisfaction and positive feedback via Staff survey;	RAG rating	Programme Phase	Start date	Complettion date	Wellness, Work and Us Lead
2.3.1	Fully implement a positive culture of psychological safety - where staff feel safe to challenge decisions and raise concerns about standards of care	Staff feel uncomfortable in speaking up and challenging decisions. This can impact on clinical safety, efficiency and clinical outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Establishment of Freedom to speak up Guardians with whom staff can have safe conversations that can be fed up to management with no implications for staff • Root cause analysis to be completed (include 3rd parties) • Reaffirm Speak out safely platform - include in Staff Briefing and Div. Workforce meeting. • Introduce DSLT Pen Portraits in the Staff Briefing • Implementation of cultural change programme to promote positive communication and management behaviours. • Roll out Divisional Annual Learning Event to include launch of reviewed/new policies • Progress with training vidoe aligned to polices recently launched, to be used as part of staff induction **Assurance actions:**	All staff feel confident to speak up when clinically appropriate to do so	Supervision and PADRs; PADR compliance and supervision measured and reported monthly (via ESR) - Baseline generated from 12 months data. **Reduction in staff grievances.**		Phase 1	Jun-22	Mar-23	Wellness, Work and Us Lead
2.3.2	Successfully implement the practical use of 'decision making tools' to enhance clinical practice	Policy and procedures have not always been made as visually accessible and easy to read as possible. This can lead to incomplete implementation of policy and procedures with associated clinical risks.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Project to develop Decision Support Tools Implement the NCISH Ligature support tool across the Division • Strengthen the process for reviewing Division policy and procedures • Set a timetable to review and update each policy, prioritising relevant policies • Consult with relevant groups and governance channels • Sign off and implement revised policies by circulation across the Division including in Staff Briefing, reaffirm in Supervision and Agenda item in PTR **Assurance actions:** • Assign clinical lead to complete annual review, support and briefing sessions to clinicians • Sampling of notes and care plans and unannounced visits	All staff have read and follow mandatory policy, procedure and guidance	**Increased staff satisfaction and positive feedback via staff survey**, supervision and PADRs; PADR compliance and supervision measured and reported monthly (via ESR) : quality checking of PADR/supervision audited quarterly against agreed standards e.g. BCUHB values, role and responsibility, reflection. **Reduction in staff grievances.**		Phase 1	Aug-22	Mar-23	Wellness, Work and Us Lead

2.4	Strengthen cohesive, multi disciplinary team working	Problem: inconsistent involvement of MDT resulting in compromised decision-making and suboptimal service user care and treatment; poor service user experience	Actions	Outcome	Targeted intervention outcome 7 evidence submission re team attendance, membership, actions	RAG rating	Programme Phase	Start date	Complettion date	Clinical Director, Central
2.4.1	Successfully promote effective Multidisciplinary team working throughout the MH&LD Division	Staff do not always work in a multidisciplinary way as often as possible and this can lead to an incomplete assessment and risk factors.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of monthly MDT meetings to discuss complex cases; clarity and expectations set in relation to the role of physio, OT, dietetics, SALT and pharmacy in the assessment and care of older persons • Review of MDT TOR's to ensure appropriate membership and reporting • Implement reviewed MDT TOR's across the Division • To strenghen feedback route for Advocates to provide servcie user feedabck (MHM part 4) **Assurance actions:** • Bi-annual audit of case notes / inclusion of MDT input	All staff will complete mandatory training within mandatory timescales	**Service User experience reports** / Quarterly review of Tor's and meeting minutes to measure that meetings have taken place and include the appropriate attendees - Baseline created from previous meetings (Quality, Frequency etc.)		Phase 1	Sep-22	Mar-23	Clinical Director Central
2.4.2	Implement effective and productive team meetings through all services in the MH&LD Division	There are many meetings however more change needs to happen as a result so they are productive	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implement Divisional cycle of business to show clear reporting lines across all meeting Tiers across the Division from local to corporate level Ensure all staff groups are involved and participate in team meetings • Review team dynamics and areas for improvement during reflective practice sessions, Supervision and team PADRs. Guidance and development for effective meeting Chairs • Implementation of team sessions to identify common purpose, team objectives i.e. review TOR's • Implementation of workforce development plan to promote good working behaviours, improve communication and efficiency. • Progress with actions from Training and Development Group **Assurance actions:** • Annual staff survey, annual governance review	All staff will complete productive meetings training within 12 months	Number of meetings planned vs completed - Baseline established from present data or target agreed for number of meetings. Agenda developed and agreed.		Phase 1	Sep-22	Jan-23	Clinical Director Central

2.5	Strengthen communication & engagement with staff and partners (internal & external)	Problem: inconsistent communication & engagement with staff resulting in staff and partners not feeling listened to and included in decision-making	Actions	Outcome	Staff survey, service user feedback e.g. Caniad; inclusive of Targeted Intervention Outcome 2 evidence submission	RAG rating	Programme Phase	Start date	Complettion date	Communication officer
2.5.1	Ensure the successful implementation of a system of bespoke, meaningful and sustained staff engagement across the MH&LD Division	Staff do not feel listened and feel disconnected from strategic decision-making. This impacts on staff wellbeing and retention.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and renew Divisional communication and engagement strategy • Ensure methods of communication used are suitable for all staff groups, ie HCA with limited email access. • Implement initiatives including: ward to board; regular staff survey, regular leadership coffee meeting with services • Directors and Senior Managers to attend local areas/team meetings on rotational basis • Review the aims and objectives of the Listening Leads and Wellbeing Champions to ensure they effectively enable staff being listened to • Engage staff in the improvement of Betsi Net MH&LD pages **Assurance actions:** • Staff survey annual monitoring	All staff feel confident, listened to, supported and enabled within a positive, healthy and culture	Overall staff engagement - Mthly Divisional Performance Reporting- baseline from 12 months previous. Percentage of staff reporting their line manager takes an active interest in their health and wellbeing - Divisional Performance Report-baseline as before		Phase 1	Jun-22	Jan-23	Communication officer
2.5.2	Full implementation of a well-managed schedule of regular briefings to staff (debrief, lessons learned)	Staff feel out of the loop with strategic decisions and programmes of change underway.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Adopt a cascade system of regular briefings for all staff at all levels • Assure lessons learned have been embedded throughout the division through a programme of regular staff satisfaction audit • Continue with Staff Briefing Newsletter, 7 minute briefings, Safety bulletins as themes of leasons learnt arise **Assurance actions:** • Staff survey annual monitoring	All staff feel confident, listened to, supported and enabled within a positive, healthy and culture	Improved staff satisfaction against a July 2022 baseline		Phase 1	Aug-22	Feb-23	Communication officer
2.5.3	Enhance open collaboration, communication and learning with external partner agencies	Staff are not working in an integrated way with partner agencies and this can impact on the opportunity for shared learning when serious incidents occur.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Development of a comprehensive stakeholder communication and engagement strategy • Map out existing and needed partners required to deliver T4MH, to ensure clear lines of communication to enable collaboration and engagement • Service User feedback to be used to inform change, with monhtly reporting to QSE • Review the current arrangements with the Joint Partnership Group meeting to ensure continued engagement with staff side representatives. **Assurance actions:** • Annual stakeholder survey	All clinicians will engage with partner agencies to ensure holistic, comprehensive and high quality care plans are in place and learning takes place	Quarterly audit of staff to identify knowledge of lessons learned- Develop baseline and target		Phase 1 & Phase 2	Aug-22	Dec-23	Communication officer

S3: Safe & effective care (Strategic Lead - HoN)		Problem	Action	Outcomes	Metrics and monitoring arrangements	RAG	Programme Phase	Start date	Completion date	Lead: Head of Nursing
3.1	Improve & strengthen the management of risk across the Division	Problem: Inconsistent adherence to risk management including assessment, formulation, application and documentation resulting in poor decision making and significant harm to patients e.g.	Actions	Outcome	Metrics and monitoring arrangements	RAG rating	Programme Phase	Start date	Completion date	Head of Governance (FM)
3.1.1	Ensure that the risk management policy and procedures are current, updated, reviewed, implemented and assured	Policy and procedures have not been systematically updated and audited fully to ensure full implementation from policy to practice.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Continue with current programme of clinical risk audits • Increase the number of staff attending WARRN training by 50% in year 1, etc. • Implement the Risk Assessment Guide whilst awaiting roll out of WARRN training • Continue with the programme of Risk Assessment training for HCA's to 50% compliance by year 1 • Ensure up to date and thereafter regular risk assessments are undertaken across the Division to identify and mitigate risks **Assurance actions:** • Annual review of policy and procedures by policy sub-group	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Signed policy documents		Phase 1 & Phase 2	May-22	Jul-23	Head of Governance (FM)
3.1.2	Consistent dissemination of a high quality induction pack for every new member of staff (which includes a copy of the 'risk management policy and procedures')	The Division is currently ensuring service continuity with a high proportion of interims. Interims have not historically been inducted consistently in current policy and procedures for managing risk.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Ensure risk management is included as part of induction process • Establish risk assessment training as part of training plans **Assurance actions:** • Annual review of policy and procedures by policy sub-group • Sampling of notes and care plans and unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Signed policy documents vs number of new starters		Phase 1	Aug-22	Dec-22	Head of Governance (FM)
3.1.3	Ensure that high quality, comprehensive and inclusive risk management plans are completed by clinical services	Staff are not consistently producing high quality risk assessment and formulation which can lead to serious incidents due to incomplete mitigation.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Audit of every risk management plan and mitigation to ensure inclusion of information from the patient, family and carers. • Continue with Implementation of training plan for all registered staff across the division. • Continue to develope training plan for all unregistered staff across the Divison • Ensure managers monitor quality of Risk Management plan **Assurance actions:** • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plans (see section 6)	All managers will ensure that high quality risk assessments are completed for every patient	95% of staff have completed risk management training; monthly measurement to be undertaken across all inpatient and community setting: 100% completed risk management plans to appropriate standard. Monitored into local QSE and issues escalated to Divisional QSE		Phase 1	Aug-22	Dec-22	Head of Governance (FM)
3.1.4	Ensure that all clinical documentation evidence clear communication and involvement of carers, families and professionals and that risk is reviewed	Poor quality clinical documentation has been noted in relation to significant harm events.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Clear and comprehensive documentation of risk assessment and management plans, inclusion in staff briefings, handovers. • Review handover proformas used across and agree a standard document to be used across the division. • Ambition to ensure all paper records are scanned onto an electronic system **Assurance actions:** • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plans (see section 6) • Sampling of notes and care plans and unannounced visits	All managers will ensure that high quality clinical notes are completed and accessible for every patient	All staff using agreed handover proforma 100% of the time (sample of documentation across the division performed on a monthly basis). Monitored into local QSE and issues escalated to Divisional QSE		Phase 1	Aug-22	Dec-22	Head of Governance (FM)
3.1.5	Implement a clear process to ensure that every member of staff will read, review and sign off an understanding of the MH&LD Div. policy and procedures relating to risk	There is a lack of assurance for all staff having read, understood and agreed to follow current risk management policy.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Audit to ensure every member of staff has signed off on policy and procedures Assurance actions: • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plan sign-offs and review by managers (see section 6) • Sampling of notes and care plans and unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	All staff using agreed handover proforma 100% of the time (sample of documentation across the division performed on a monthly basis). Monitored into local QSE and issues escalated to Divisional QSE		Phase 1	Aug-22	Mar-23	Head of Governance (FM)
3.2	Reducing the risk of ligature incidents	Problem: ligature incidents resulting in significant learning opportunities for the organisation	Actions	Outcome	Reduction in ligature incidents and subsequent harm	RAG rating	Programme Phase	Start date	Completion date	Head of Governance (GK)
3.2.1	Implement a system of high quality risk assessment and formulation in relation to ligature	A review of recent ligature incidents has indicated that risk assessments were either not fully completed.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of a programme of ligature risk training for staff on risk policy • Introduce robust process for investigating ligature incidents **Assurance actions:** • Annual review of risk policy and procedures by policy sub-group / Quarterly review of risk management plans (see section 6)	All managers will evidence that every member of staff has read, understood and is following the policy relating to managing risk relating to ligature.	All inpatients (100%) to have a risk assessment and risk management (to include environmental risks) plan in place; monthly sample measurement of inpatient documentation supplemented with a full annual clinical risk audit		Phase 1	Aug-22	Oct-22	Head of Governance (GK)
3.2.2	Ensure that comprehensive and uptodate envirnomental risk assessments are completed to identify, reduce and mitigate the risk of ligature incidents (*see also Environmental and resources work stream*)	Equipment has not been replaced to address safety risks identified.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Project to review and improve ligature safety of facilities and equipment within settings i.e. Estates review **Assurance actions:** • (see section 5 and section 6) • Annual anti-ligature risk assessment of estates • Routine anti-ligature risk assessment of estates • Sampling of risk assessmenets and unannounced visits	All MH&LD Estates will have an uptodate anti-ligature risk assessment and health and safety status	All inpatients to have a risk assessment and risk management (to include environmental risks) plan in place - Weekly review & Baseline developed from QSE records. monthly measurement of inpatient documentation supplemented with a full annual clinical risk audit		Phase 1	Jul-22	Dec-22	Head of Governance (GK)
3.2.3	Ensure that patient visibility is assessed and actions implemented in accordance with the Division's policy and procedures in all inpatien settings	A review of recent ligature incidents has indicated that issues have not been fully resolved relating to patient visibility.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Project to review and improve ligature safety of facilities and equipment within settings (see section 5) • Review and update of ligature policy and procedures • Ensure health and safety policies are in place and easily accessible by all staff **Assurance actions:** • Establish clear links between Div level risk management processes for Estates, Facilities and Clinical Services • Strengthen the Estates input to risk management	All managers will evidence that eachy member of their team has read, understood and is following the policy relating to managing risk relating to ligature.	Observation checks documented and checked - Baseline from current data. Reported weekly.		Phase 1	Aug-22	Dec-22	Head of Governance (GK)

3.2.4	Ensure that the current ligature policy and procedures are reviewed, up to date and disseminated to all staff	A review of recent ligature incidents has indicated that risk assessments were either not fully completed or mitigations were not fully implemented.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and update of ligature policy and procedures • Ensure health and safety policies are in place and easily accessible by all staff **Assurance actions:** • Quarterly monitoring of signed confirmation of having read risk policy and procedures / spot checks with managers to ensure monitoring is taking place	All managers will evidence that every member of staff has read, understood and is following the policy relating to managing risk relating to ligature.	95% of all staff have received policy & procedure and confirmed understanding by sign off and within supervision**this is to provide some tolerance within the system for the timeframe due to such things as long term sickness, unexpected absence etc.*		Phase 1	Aug-22	Oct-22	Head of Governance (GK)

3.3	Ensure all observations are at the appropriate level to ensure they are safe and therapeutic	Problem: Incident investigation learning has shown that the level of therapeutic engagement and observations have been inadequate and unaligned to	Actions	Outcome	Reduction in harm (via reduction in incidents relating to patient therapeutic observations); improved service user satisfaction and positive experience reported via service user experience feedback	RAG rating	Programme Phase	Start date	Complettion date	Head of Governance (GK)
3.3.1	Ensure that physiological and mental health assessment and observations are undertaken in all inpatient settings	The implementation of therapeutic observations has not always been completed to the optimum level of frequency, which can have implications for managing risk.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Briefing sessions, training programme and audit programme developed. **Assurance actions:** • Quarterly monitoring of signed confirmation of having read therapeutic observations policy and procedures / spot checks with managers to ensure monitoring is taking place	All managers will evidence that every member of staff has read, understood and is following the policy on therapeutic observations.	Percentage of mental health assessments undertaken (up to and including) 28 days from the receipt of referral for people aged under 18 years - Divisional Performance Reporting Baseline from 12 months previous. Weekly review via Quality Checks (Ward Manager/Matron) of observation charts and documentation: 100% of patients to have documented observations as per individual care plan.		Phase 1	Aug-22	Sep-22	Head of Governance (GK)

3.4	Reduction of incidents in relation to falls, medication errors and the deteriorating patient	Problem: Incidents have identified that patients experience avoidable falls, medication errors and failure to recognise physical health deterioration across the Division	Actions	Outcome	Reduction in falls rate i.e. per bed days, falls with harm (via Datix), reduction in medication error rate, reduction in incidents relating to deteriorating patients (physical health)	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
3.4.1	Ensure that risk assessments are completed to identify, reduce and mitigate the risk of Falls with active prevention measures assured	Themes and trends relating to falls, broken down by profession, are not reported currently in a way to embed the learning into the planned transformation work.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review / develop falls risk assessment process and document • Ensure all patients are risk assessed for falls • Project to review and reduce falls • Introduction of a sustained campaign of best practice examples in Falls reduction/ prevention across Elderly Mental Health Care in North Wales **Assurance actions:** • Annual audit / spot checks of risk assessments	All managers will evidence that every eligible patient has had a risk assesmsent completed (with falls included where clinically appropriate).	Falls resulting in harm or death/Number of inpatient falls - reported via QSE Agenda. Weekly sample of documentation to measure falls risk assessment compliance (aiming for 100%); and falls care plan/pathway in place (aiming for 100%) - Baseline generated		Phase 1 & Phase 2	Aug-22	Jul-23	Quality and Safety Lead
3.4.2	The service will ensure that medication and treatment plans are up to date, with clear review timescales included and with plans reviewed and updated (where appropriate)	Medication has been prescribed, without clearly stated and specific treatment goals, noted as set with the patient, taking into account any risks (including interactions), with a stated timescale for review and patient consent recorded.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review / develop medicines management policy and ensure it is easily accessible to staff • Develop template for medication review discussions with patients including consent and timetables reviews • Establish a process to review staff competencies every three years • Identify a link pharmacist to multi disciplinary teams **Assurance actions:** • Annual audit • Sampling of medical notes, treatment plans and unannounced visits	All medical patients will have clear, complete and accurate information relating to treatment, including medication and a time for review.	monthly inpatient medication review audit to identify any gaps in undertaking reviews with improvement plans and actions in place, Reduction in medicine incidents to be monitored weekly - Baseline generated from current data.		Phase 1	Aug-22	Dec-22	Quality and Safety Lead
3.4.3	Ensure that there is a rapid and effective response to the identification of an acutely ill (deteriorating) patients by clinical services	Deterioration in the condition of some patients has not been identified quickly enough in some cases, which can lead to avoidable harm.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of a programme of training for staff observations based on Div policy and procedures • Introduction of the All Wales systems in 'recognition of the deteriorating patient' across elderly mental health services in North Wales **Assurance actions:** • Annual audit / spot checks	All staff will complete mandatory training within mandatory timescales	% trained in NEWS and recognition of the deterioration for all registered staff; 95% of registered staff trained measured via training records, to be reviewed on a quarterly basis to pick up on new starters etc. Baseline to be established from existing records.		Phase 1	Aug-22	Mar-23	Quality and Safety Lead

3.5	Improving the recognition of safeguarding adults at risk and ensuring the appropriate pathway is followed	Problem: lack of recognition of safeguarding issues and appropriate intervention and referral	Actions	Outcome	Reduction in safeguarding incidents	RAG rating	Programme Phase	Start date	Completion date	Safeguarding Lead
3.5.1	Ensure all staff are fully trained to the appropriatel level of safeguarding training & awareness of policy	Staff have not always followed the internal safeguarding policy and procedures in full, which means that potential risks could have been averted.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and update of internal safeguarding policy and procedures • Monitor safeguarding training is completed as part of mandatory training requirements • Review the process for restraints, restrictions, seclusion to ensure they are compliant and appropriately applied **Assurance actions:** • Monthly monitoring of staff training compliance	All staff will complete mandatory training within mandatory timescales	Number of policy infractions - Baseline developed from existing data. (Training records; 95% of all staff have received policy & procedure and confirmed understanding by sign off and within supervision; safeguarding referrals rate**this is to provide some tolerance within the system for the timeframe due to such things as long term sickness, unexpected absence etc.)*		Phase 1	Aug-22	Oct-22	Safeguarding Lead
3.5.2	Ensure that advance planning is incorporated as part of full implementation of the Division's policy and procedures relating to the use of restrictive interventions	A lack of advance planning with patients has lead to an excessive number of incidents being managed with restrictive measures unnecessarily	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review and update of policy and procedures • To reduce the use of restrictive interventions, patients who have been violent, aggressive or communicating distress are supported to identify triggers and early warning signs, and make advance statements about the use of restrictive interventions. • Progress programme of training (RESPECT, PICSS) impacted by Covid **Assurance actions:** • Quarterly audit of practice / annual review of policy and procedures • Sampling of notes and care plans and unannounced visits	All staff will complete mandatory training within mandatory timescales	95% Staff appropriate for Training in RPI - training records; RPI reported via Datix - reported at a local and divisional QSE level / Establish baseline and provide SMART measure in response		Phase 1	Aug-22	Sep-22	Safeguarding Lead

S4: Individual & Timely Care (Strategic Lead - HoO)		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Ops Lead**
4.1	Right care at the right time in the right place	Problem: Patients are experiencing long waits for mental health input, and appropriate placement suitable for their needs.	Actions	Outcome	Reduced waiting times from referral to assessment and treatment-% improvement on baseline, Reduced waiting times for placements -% improvement on baseline ;no Datix for mixed cohorts (reporting via the Mental Health Measure i.e. Number of mixed cohorts - %improvement on baseline); increase in service user satisfaction (% improvement on baseline) and positive feedback	RAG rating	Programme Phase	Start date	Completion date	Head of Nursing

4.1.1	Ensure that there will be no mixed cohorting of mental health patients within North Wales	The environment does not promote privacy and dignity for the patient group. There are multi occupancy rooms and the bathrooms are shared between the patients on that ward. There were limited designated male and female facilities.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Terms of Reference of Project Group to be established **Improvement actions:** • Review of patient areas to introduce male and female designated facilities (co-produce solutions with patients) • Full implementation of 4 phase process (currently phase 2) • Assign Estates Lead from cohort to support process • Estates feasibility study (see section 5) • Development of a bed management strategy to manage the demand of in-patient beds **Assurance actions:** • Quarterly audit of mixed cohorting • Spot checks / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	Reduction in Datix of any reported mixed cohorts / Continued to be monitored via exception reporting. Baseline to be developed and % improvement to be monitored.		Phase 1	Mar-22	Aug-22	Head of Nursing
4.1.2	Ensure patients are seen in accordance with Mental Health Measure timescales and as per national standards	Patients are not seen consistently from referral to assessment / treatment and greater progress is required.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Development of a performance management strategy to address areas of underperformance **Assurance actions:** • Monthly performance monitoring	All patients will be seen within mandatory timescales	Improvement in waiting times from referral to assessment and treatment (% improvement on Baseline); reported into Finance & Performance / Improvement trajectory to meet KPI's to be reported e.g. psychological therapies		Phase 1	Sep-22	Mar-23	Head of Nursing
4.1.3	Ensure that every CHC placement plans is of a high quality, comprehensive and person-centred	CHC plans are not as comprehensive and person-centred as they could be. This can lead to sub-optimal outcomes and increased cost implications from unmet need.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Review of placement plans **Assurance actions:** • Quarterly audit programme of placement plans by managers	All patients will participate in the development of a comprehensive, holistic outcomes-based care plan	Delayed transfers of care reported via F&P /divisional SLT-% improvement on baseline		Phase 1	Aug-22	Dec-22	Head of Nursing

4.2.	Review of current service processes to optimise patient journey	Problem: Gaps in core service processes- to be identified and addressed to meet population needs	Actions	Outcome	Inpatient and community establishment review; pathway development	RAG rating	Programme Phase	Start date	Complettion date	Head of Nursing
4.2.1	Ensure that the whole system of support is mapped clearly from the service user's perspectice and produced into a clear directory of services that can improve access for all patients	There is no easily available directory of services that includes the full system of support in North Wales	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Completion of service mapping project including iCan • Development of patient journey through services and ways to improve streamlined transfer • Development of Service Directory available online Progress with Do Well Workshops to review T4MH Strategy **Assurance actions:** • Review of implementation of recomendations and review of current system with service users	All staff and patients will have clear information on the range of support available to enable their wellbeing and mental health needs	* to be determined following analysis		Phase 1	Aug-22	Dec-22	Head of Nursing

4.3	Improve Individualised Care planning to promote independence	Problem: Not all care plans are completed and reviewed collaboratively, to the required standard, resulting in variation in care and service delivery and patient experience across the	Actions	Outcome	Mental Health Measure ; Improvement in service user satisfaction and positive feedback	RAG rating	Programme Phase	Start date	Complettion date	Head of Nursing
4.3.1	Ensure that every client participates in the development of high quality, individualised & comprehensive care planning	All care plans do not show sufficient evidence of an individualised and holistic outcomes based approach.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Improvement plan implemented based on root cause analysis findings **Assurance actions:** • Quarterly audit of care plans to ensure promotion of independence • Spot checks of care plans / unannounced visits	All patients will participate in the development of a comprehensive, holistic outcomes-based care plan	% of care plans are completed and reviewed to the required standard: monthly sample measurement supplemented by annual audit. Baseline rom existing data.		Phase 1	Aug-22	Jan 2023	Head of Nursing

4.4	Ensure Admission, Discharge and Patient Leave processes are fully documented and communicated, and follow BCUHB Polices/Procedures	Problem: Documentation is not always clear in a patients admission, discharge and leave status resulting in incidents relating to communication and informing	Actions	Outcome	Reduction in patient safety incidents relating to admission, discharge and leave; Increased service user satisfaction and positive experience via Service User Experience Feedback	RAG rating	Programme Phase	Start date	Complettion date	Head of Nursing
4.4.1	Ensure that Admission processes are well planned, fully documented and comprehensive	The admission policy has been inconsistently implemented resulting in physical health conditions not being identified, user defined goals not being completed and patient preferences re: confidentiality / information sharing not being recorded.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Plan to improve management of admission process - how? • Patients have follow-up investigations and treatment when concerns about their physical health are identified during their admission **Assurance actions:** • Quarterly audit of admission paperwork • Spot checks of care plans / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	Monthly review to be undertaken across all inpatient and community setting as part of Quality Check: 100% completed admission criteria to appropriate standard. Baseline to be generated. % improvement on baseline.		Phase 1	Aug-22	Oct-22	Head of Nursing
4.4.2	Ensure that Discharge processes are implemented consistently with patient safety, recovery and proactive follow ups are completed every time	The a discharge policy has been inconsistently implemented resulting in patient treatment goals not being reviewed, post-discharge plan not being completed and mandatory follow ups not being completed within timescales.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Plan to improve management of discharge process **Assurance actions:** • Quarterly audit of discharge paperwork • Spot checks of care plans / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	Number of incidents relating to admission, discharge and leave (see 1.1.3) % improvement on baseline. 100% completed discharge planning measured against required standard - % improvement on baseline; Patients followed up within 72 hrs post discharge from psychiatric setting *95% level to provide tolerance for any issues that arise e.g., service user contact .		Phase 1	Aug-22	Nov-22	Head of Nursing
4.4.3	Ensure that the current policy and procedures relating to the 'management of patient leave' are understood, fully implemented and assured	Patients have been granted leave with inadequate patient leave planning and tracking resulting in serious incidents due to lack of management, record keeping and coordination.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Plan to improve management of patient leave process **Assurance actions:** • Quarterly audit of leave paperwork • Spot checks of care plans / unannounced visits	2 wards to progress towards Gold Ward Accreditation, 3 bronze to silver and 3 white to bronze in year 1	monthly measurement to be undertaken across all inpatient and community setting: 100% completed leave risk assessment and decision making documented to appropriate standard		Phase 1	Aug-22	Dec-22	Head of Nursing

4.5	Listening and learning from patient & carers/family feedback	Problem: lack of dedicated time to listen and understand the patient experience to make service improvements	Actions	Outcome	Increased service user satisfaction and positive experience via Service User Experience Feedback; inclusive of Targeted Intervention Outcome 2	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead

4.5.1	Every clinical service will ensure that Patient & carer experience/feedback is proactively sought, systematically reviewed and utilised to drive service improvements	Service user feedback is not systematically used to drive service improvement.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current feedback with parents and carers re: specific service experience • Include service user representation within Div Imp Plan project review process **Improvement actions:** • Review current service user engagement mechanisms • Develop a Divisional model and plan for service user engagement (online/open days) including FT Engagement Facilitator role. Build in evaluation of engagement approach from staff, patient, carer and partner perspectives • Increase number of Service user on interview panels **Assurance actions:** • Bi-annual audit presented to Patient Carer Experience meeting (PCE)	All services will understand the value of including patient and carer experience information to inform team meetings and planning on a monthly basis	Service User/Carer Experience Feedback Monthly report and development of % improvements in response 'you said we did' ; reported into patient experience group. Baseline established from existing data.		Phase 1	Jun-22	Dec-22	Quality and Safety Lead
4.5.2	Every clinical services will ensure that patients & carers/families are involved in the planning of high quality patient care and clinical records	Holistic care planning is not systematically mainstreamed across clinical practice, in part impacted by staffing level challenges, however, a holistic and comprehensive assessment with carers / families is required to assure a complete risk assessment and plan have been completed.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current feedback with parents and carers re: specific service experience • Include service user representation within Div Imp Plan project review process **Improvement actions:** • Review quality of clinical records • Review staffing levels and develop plan to optimise capacity • Develop policy, procedures for co-production / parent / carer involvement **Assurance actions:** • Annual co-produced review of service user engagement and operationalisaion of recommendations into service delivery and improved outcomes	All care plans will show evidence of carer, familiy, participation / invitation to be involved (where clinically appropriate)	Monthly report of Service User/Carer Experience Feedback and development of improvements in response 'you said we did' ; reported into patient experience group		Phase 1	Aug-22	Feb-22	Quality and Safety Lead

4.6	Provide patient information (for patients & about patients) in multi-formats	Problem: current patient information is not always user friendly or in multi formats e.g. different languages, accessible to [illegible]	Actions	Outcome	Service user experience feedback; accessible healthcare audit	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
4.6.1	Every service will ensure that information for patients, carers and family is clear, accessible and up to date	Information for patients has not been reviewed and updated regularly - patients tell us the information is unclear and needs to be presented in different languages to be accessible.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current service user information **Improvement actions:** • Develop a plan for service user information • Develop easy read documentation for patients • Each inpatient unit to create an patient information pack (bilingual) • Assess the need to have patient douc mentation and information in other languages **Assurance actions:** • Bi-annual audit of info with Caniad	All information for patients, carers and familiy, will be reviewed and updated, on an annual basis	Target number of languages vs Actual number - Baseline established from current availability. Monthly report of Service User/Carer Experience Feedback and development of improvements in response; improvements actioned if identified via Accessible Healthcare Audit		Phase 1	Aug-22	Dec-22	Quality and Safety Lead
4.6.2	Every service will ensure that information about patients, carers and family is clear, accessible and up to date	Information about patients has not always been shared with patients in a way to inform how a patient can engage with the service and or other methods of support to meet their needs	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review current service user information **Improvement actions:** • Develop a plan for service user information • Develop patient journey document to share with patients for both inpatients and community service users • Develop family and carers information sheet, to include liaison wiht families and carers to ensure approrpoaite for thier needs **Assurance actions:** • Bi-annual audit of info with Caniad	All patients will be shared information about support, services avaialble, in a format that is accessible to meet their linguistic, cultural and cognitive requirements	Annual documentation audit with improvement plan identified if necessary; this will include information from other document checks as per previous tasks e.g. risk assessments, admission criteria		Phase 1	Aug-22	Mar-23	Quality and Safety Lead

S5: Environment, Resource & Workforce (Strategic L		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Planning Lead**
5.1	Understanding Roles, capability - skills, knowledge & practice	Problem: not all staff are the right staff in the right roles at the right time impacting on staff well being, management and leadership, and variation and suboptimal patient care and experience	Actions	Outcome	E-roster analysis; reduction in bank/agency & overtime usage; reduction in workforce concerns; improved training compliance; PADR compliance and sickness absence; Baseline developed for each and improvement plan developed.	RAG rating	Programme Phase	Start date	Complettion date	Head of Workforce
5.1.1	Every manager will ensure that clear opportuntiies are provided to staff to enhance their skills, knowledge and clinical practice as part of a robust PADR process	Staff require opportunities to develop their skills to meet service gaps and in order to progress towards career development opportunities.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Training Needs Assessment progressed • Implementation of workforce plan, aligned to career development opportunities **Assurance actions:** • Annual review and audit • Spot checks of PADRs / unannounced visits	All staff will have a high quality PADR within mandatory timescales	95% of all staff to have up to date PADRs - captured via ESR **this is to provide some tolerance within the system for PADRs not completed within the timeframe due to such things as long term sickness, unexpected absence etc. / E-Rostering; staff reported issues via Datix. Baseline created from existing data.*		Phase 1	Aug-22	Dec-22	Head of Workforce
5.1.2	Every manager will ensure that sufficient time is available for supervision & reflection	Staff have communicated that they do not get enough time for reflective practice due to the pressures of working culture	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Implementation of workforce plan (see workforce workstream), aligned to reflective practise **Assurance actions:** • Annual review and audit	All staff will have a supervision session within mandatory time frames	95% staff to have monthly supervision		Phase 1	Aug-22	Dec-22	Head of Workforce

5.2	Managing Daily caseload and staffing incl. rostering	Problem: Staff are not always as diligent in the management of safety and risk	Actions	Outcome	E-roster analysis to establish current situation; Cost of bank; Cost of Overtime, Cost of Agency - Reported via QSE Agenda (Baseline established from existing data). % reduction in bank/agency & overtime usage; % reduction in workforce concerns; improved training compliance; increased PADR compliance and reduction sickness [illegible]	RAG rating	Programme Phase	Start date	Complettion date	Head of Planning and Performance
5.2.1	Every manager will ensure that clear standards for 'Forward planning' are in place, monitored, managed and actioned	Staff have not been forward planning to ensure that sufficient capacity is assured for service delivery.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Briefing to managers **Improvement actions:** • Demand and capacity review completed • Case load analysis aligned to national baseline recommendations • Implementation of workforce plan (see workforce workstream) • Review of Estates and Facilities requirements to meet workforce requirements **Assurance actions:** • Monthly monitoring by SLT	All managers will create, monitor and manage clear demand and capacity projections based on safe staffing levels	E-roster analysis to establish current levels. Cost of bank/agency & overtime usage reported in QSE Agenda; caseload monitoring Baselines created from existing guidelines or data		Phase 1	Jun-22	Apr-23	Head of Planning and Performance

5.2.2	Every manager overseeing recruitment actions will prioritise and complete actions in a timely manner	A high number of vacancies is impacting on service capacity and access times for services.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Re-affirm E roster KPI's with managers • Progress with Just R 12 month recruitment campaign • Review of current Agency spend/usage **Improvement actions:** • Develop recruitment strategy • Briefing sessions for manager aligned to capacity planning/management • Recruit to permanent positions / fill interim posts • Implementation of workforce plan including monitor / review of metrics to show return on investment of Just R • Review of Estates and Facilities requirements to enable new posts **Assurance actions:** • Monthly monitoring by SLT	All services will ensure recruitment to safe levels of establishment are achieved and maintained	Number of Responses vs Interviewed, Number of Interviewed vs Successful, Conversion rate - % improvement from baseline from existing data		Phase 1	Aug-22	Apr-23	Head of Planning and Performance

5.3	Well organised and safe working environment incl dignity i.e. privacy	Problem: Inadequate environmental estates leading to a poor experience and impacts on patient safety and safe working conditions for staff	Actions	Outcome	Use of existing organisational audits to provide divisional data/measures: H&S environmental audits; IPC audits; ward accreditation; safe clean care audits	RAG rating	Programme Phase	Start date	Complettion date	Assistant Director of Nursing
5.3.1	Every clinical environment will be managed in a way to ensure 'privacy and dignity' is at the heart of clinical delivery at all times	The Division's Estate is not designed to be fit for purpose resulting inconvenient adaptations to service delivery required to ensure Privacy and Dignity are assured.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of any risk / exception reports **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Review of Estates priorities • Development of Estates strategy collaboratviely developed with Estates, Health and Safety and Operational colleagues **Assurance actions:** • Annual audit and review • Spot checks / unannounced visits with patient representatives	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	Use of organisational audit programmes to provide data at a divisional level: H&S environmental audits; IPC audits; ward accreditation; safe clean care audits, ensuring that improvement plans are developed if appropriate. Baselines developed for each measure with % improvements agreed.		Phase 1	Jun-22	Dec-22	Assistant Director of Nursing
5.3.2	Ensure that each clinical setting is well organised and fit for purpose to optimise patient experience, safety and quality outcomes	There have been delays in getting identified changes to Estates and Facilities completed. Business cases have been submitted without sufficient Capital available to enable a speedy resolution. New ways at looking at old problems are required to create safe and clinically effective environments that enable patient outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of current allocated Capital for MH&LD Estates requirements • Review of available capital spend from last 3 years • Review requirements to recruit a ML&HD Estates person to be visible and available re: MH&LD clinical requirements **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Review of Estates priorities • Development of Estates strategy **Assurance actions:** • Annual audit and review • Spot checks / unannounced visits with patient representatives	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	Use of organisational audit programmes to provide data at a divisional level: H&S environmental audits; IPC audits; ward accreditation; safe clean care audits, ensuring that improvement plans are developed if appropriate. Baselines developed for each measure with % improvements agreed.		Phase 1	Aug-22	Mar-23	Assistant Director of Nursing
5.3.3	Ensure that 'environmental risk assessments' are completed, managed, safety requirements approved and implemented in a timely manner	There have been delays in getting identified changes to Estates and Facilities completed. Business cases have been submitted without sufficient Capital available to enable a speedy resolution. New ways at looking at old problems are required to create safe and clinically effective environments that enable patient outcomes.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of current allocated Capital for MH&LD Estates requirements • Review requirements to recruit a ML&HD Estates person to be visible and available re: MH&LD clinical requirements **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Guttering assessment (in relation to ligature) to be included in plan • Strengthen local Estates meeting with clear governance to ensure actions progressed • Strengthen local and Divisional Health and Safety meeting with clear govenrance to esnure actions progressed **Assurance actions:** • Annual audit and review	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	All areas hosted by the division to have Environmental risk assessments undertaken; monitored by H&S divisional meeting aligned with corporate H&S meeting		Phase 1	Aug-22	Dec-22	Assistant Director of Nursing
5.3.4	Ensure that estates are designed and adapted to be safe and in particular reduce the risk of violence & aggression in the workplace	Buildings are not designed in a way to optimise safety for staff and patients.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities **Improvement actions:** • Development of a standard to be agreed between Estates and Clinicians • Review of Estates priorities to promote dignity • Development of Estates strategy • Implementation of policy review and training programme • Design standards to be developed and agreed (a long term issue as there is no capital to deliver in the short-term) **Assurance actions:** • Annual audit and review	All MH&LD Estates will be compliant with BCU Health and Safety policy, regulations and and mental health best practice standards	Reduction in reported incidents in relation to V&A (patient on patient, patient on staff etc.) .Monitored via Datix and Physical Intervention and support service - reported into QSE		Phase 1	Aug-22	Dec-22	Assistant Director of Nursing

S6: Audit, Outcomes and Assurance (HoG / HoF)		**Problem**	**Action**	**Outcomes**	**Metrics and monitoring arrangements**	**RAG**	**Programme Phase**	**Start date**	**Completion date**	**Lead: Governance Lead**
6.1	Strengthening Governance, risk and course correction (learning)	Problem: ineffective governance processes at every level resulting in increased significant incidents, staff and service user concerns	Actions	Outcome	Reduction in patient safety Incidents, complaints and increase in compliments ; Inclusive of Targeted Intervention Outcome 7 submitted evidence	RAG rating	Programme Phase	Start date	Complettion date	Head of Governance
6.1.1	Ensure that a clear governance framework is in place with explicit roles and responsibilities and clear reporting and escalation procedures	Staff have indicated a lack of clarity about roles and responsibilities within the process of governance.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Full development of the Divisional Cycle of Business (Targeted Intervention level 2 measure) (underway) **Improvement actions:** • Implementation and dissemination of Cycle of business • Staff training to acheive understanding of governance structures and processes • Audit of meeting TOR's across the Division **Assurance actions:** • Annual review	All meetings held across the Division will have an up to date TOR, with clear lines of reporting, escaltion and disemmination.	Inclusive of Targeted Intervention Outcome 7 submitted evidence / In place; currently being reviewed against operating model (which is awaiting to be agreed)		Phase 1	Aug-22	Dec-22	Head of Governance
6.1.2	Review and strengthen the process for managing allegations/incidents in line with Safeguarding and WOD processes	Reviews of incidents indicate that awareness of safeguarding policy and processes needs to be strengthened.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of safeguarding incidents and root cause analysis **Improvement actions:** • Development of safeguarding improvement plan (Triangulation of themes/trends) • Review and update its safeguarding training and ensure it is up to date and incorporates relevant legislation, safeguarding documentation, audits • Planned schedule of reflective learning sessions **Assurance actions:** • Annual audit	All staff are compliant with safeguarding mandatory training requirements	Reduction in Incidents reporting significant harm, complaints and an increase in compliments data: compliance with concerns KPI's e.g. 30 day response rate; monitored at local and divisional PTR feeding into QSE. Baseline available from existing reporting.		Phase 1 & Phase 2	Aug-22	Apr-23	Head of Governance

6.2	Knowing how I am doing - continuous audit cycle plan	Problem: incomplete data to support improvements leading to inefficient and unsafe processes	Actions	Outcome	Audit cycle in place and reviewed and monitored regularly	RAG rating	Programme Phase	Start date	Complettion date	Head of Governance

6.2.1	Ensure a comprehensive measuremen and audit plan is developed, resourced, implemented and assured	Many metrics are recorded and reported while the data is not linked as well as it could be and some services are using paper records.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review of current Div. reporting and requirements **Improvement actions:** • Review feasibility of recruiting to a Div self-audit team • Project to strengthen the Div. performance dashboard including demand and capacity dashboard **Assurance actions:** • Annual audit	All clinicians will have access to the North Wales implementation of the All Wales WCCS IT System to support high quality clinical records	Annual review of all tiers of audits		Phase 1	Aug-22	Sep-22	Head of Governance

6.3	Improve & strengthen the implementation of policy-driven clinical practice across the Division	Problem: inconsistent adherence to MH&LD policy and procedures can lead to risk in patient safety, clinical outcomes and patient experience.	Actions	Outcome	Incidents / Complaints due to avoidable risks.	RAG rating	Programme Phase	Start date	Complettion date	Quality and Safety Lead
6.3.1	Ensure that all staff are fully awareness of current BCU and Division policy and procedures	Some staff are unaware of existing or latest policy and procedures. Impact: inconsistent clinical practice. Risk: impact on clinical safety, outcomes, patient experience.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Briefing to be distributed to all teams - policy and procedures access • Introduction of Policy of the month in the Staff Briefing to include in Supervision/Team meetings **Improvement actions:** • Policy recommendation: risk management included as standing agenda item (operational teams) • Induction pack updated with policy and procedures link **Assurance actions:** • Annual audit • Spot checks / unannounced visits / observations	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Policy survey completed		Phase 1	Aug-22	Jan-23	Quality and Safety Lead
6.3.2	Review, strengthen and optimise how staff can access policy and procedures	Some staff are unaware of how to access the policy and procedures.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review that all policy and procedures are available on the MH&LD Hub Betsinet and all staff know how to access them **Improvement actions:** • Desktop icon to policy and procedures to be installed by IT **Assurance actions:** • Annual audit hard copy policies and procedures to ensure all old versions removed • Spot checks / unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Signed policy documents		Phase 1	Jul-22	Jan-23	Quality and Safety Lead
6.3.3	Ensure that there is a process in place to monitor and update the Division's policy and procedures within prescribed review timescales	Inconsistent implementation of policy and procedures must be identified and addressed. Impact: policy not followed and inconsistent clinical practice. Risk: impact on clinical safety, outcomes, patient experience.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Governance in place and programme of review and updating underway **Improvement actions:** • Project to review all Div. policy and procedures • Consider implementation of on line versions **Assurance actions:** • Annual audit of management evidence procedures • Spot checks / unannounced visits	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Policy Sub-group audit		Phase 1	Aug-22	Jan-23	Quality and Safety Lead
6.3.4	Ensure that a policy improvement plan is developed, fully implemented and assured	The current policy improvement plan may require some adjustments in relation to any issues identified above.	**Immediate assurance actions:** • Rapid review of root cause analysis to inform improvement activities • Review policy development capacity required for North Wales and recruitment of dedicated policy officer capacity **Improvement actions:** • Project to improve / update Div. policy and procedures **Assurance actions:** • Annual audit of policy and procedures	All managers evidence that staff have read, understood and follow mandatory policy, procedures and guidance	Policy improvement plan signed off		Phase 1	Aug-22	Jan-23	Quality and Safety Lead

6.4	Strategy, Model of Care and Operating Model development	Problem: there is no current explicit Model of Care to form the strategic Vision of how North Wales Mental Health Services will operate in the Medium / Long term	Actions	Outcome		RAG rating	Programme Phase	Start date	Complettion date	Medical Lead
6.4.1	Complete the development of a Clinical Strategy, Model of Care and Operating Model	A lack of capacity for developing and implementing clinical strategy	**Immediate assurance actions:** • Rapid review of current work completed by Clinical Strategy Group **Improvement actions:** • Allocation of Clinical Lead • Allocation of Project Manager capacity • Alignment with Together 4 Mental Health Strategy development process • Consultation with stakeholders in T4MH workshops • Completion of final documentation for Clinical Strategy, Div Model of Care and Div Operating Model • Identification of care pathway implementation i.e. project manager requirements **Assurance actions:** • Annual review of Clinical Strategy	The Mental Health & Learning Disabilities Division will have a clear unifed all age mental health strategy focused on supporting current and projected population health needs	Quadruple Aim objectives		Phase 1	Aug-22	Dec-22	Medical Director
6.4.2	Ensure the development of overarching public health outcomes model is selected / developed to align to the Div Imp Plan	Lack of alignment between population health assessment and divisional resource planning	**Immediate assurance actions:** • Clearly defined KPIs with baseline provided within MH&LD Div Imp Plan (see tab called KPIs) **Improvement actions:** • Establish public health and MH&LD outcomes / performance working group • Establish strategic outcomes in conjunction with T4MH Strategy, Clinical Strategy, Model of Care, Operating Model lead **Assurance actions:** • Co-review of population health outcomes + Div KPIs to evidence improvement based on successful implementation	The Mental Health & Learning Disabilities Division will have a clear strategic outcomes framework which will form the basis of all project initiatives	Quadruple Aim objectives		Phase 1	Dec-22	Mar-23	Medical Director

Timescales for designing and agreeing the MHLD Improvement Plan

		Completion by:	Status as of 20 June 22:
Tier 1:	Triangulation of the reports, action plans, intelligence, and existing improvement work	30-Jun-22	Complete
	Creation of a MHLD improvement plan based upon above triangulation, populated to workstream level	30-Jun-22	Complete
Tier 2:	Population of workstreams to key sub-theme level	30-Jul-22	In progress
	Allocation of workstream leads	30-Jul-22	In progress
Tier 3:	Population of project themes with task level detail, measures, and timescales	30-Aug-22	In progress

KEY PERFORMANCE INDICATORS - MH&LD DIV IMPROVEMENT PLAN - Year 1

Section	Metric	Data Source	Baseline - March 2022	Projected % Improvement	Incremental improvement trajectory - 30/09/22 Planned	30/09/22 Actual	28/10/2022 Planned	28/10/2022 Actual	30/11/22 Planned	30/11/22 Actual	31/12/22 Planned	31/12/22 Actual	31/01/23 Planned	31/01/23 Actual	28/02/23 Planned	28/02/23 Actual	31/03/23 Planned	31/03/23 Actual	30/04/23 Planned	30/04/23 Actual	Commentary
1	**FUNDAMENTALS OF CARE**																				
	All staff have a comprehensive understanding of their roles & responsibilities																				
	Mandatory Training, Level 1 and Level 2 compliance to increase from 80.9% to 85%, relevant to post.	Divisional Performance Report	80.90%	5%																	
	PADR compliance increase from 78% to 85%	Divisional Performance Report	78.00%	9%																	
	Supervision compliance increase from 693 to 3036	Divisional Performance Report	693	338%																	
	Ward accreditation - increase number of White standard wards from 3 to 0	Ward Accreditation	3	100%																	
	Improve record keeping in line with BCU policy/procedure, guidance e.g. MHM & Mental Health Act																				
	Information Governance Training - compliance to remain above 85%	Divisional Performance Report	85.23%	0.00%																	
	Review Inpatient/ward based care processes e.g. ward rounds, shift handovers, Patient Status At a Glance																				
	Reduction in the number of delayed discharges patients from 18 To 9	Divisional Performance Report	18	50%																	
	Reduction of DTOC bed days from 1125 to 563	Divisional Performance Report	1125	50%																	
	Improve the delivery of care to patients with Dementia																				
	Dementia Awareness training compliance increase from 78% To 85%	Divisional Performance Report	78%	9%																	
	Improve the delivery of Crisis Care including psychiatric liaison																				
	Emergency Department - increase % of service users assessed by Psychiatric Liaison within one hour from 62.5% To 80%	USC report	62.50%	28.00%																	
	Maintain 100% of service users, admitted to hospital who have not received a gate keeping assessment by the CRHT service that have received a follow up assessment by the CRHT service within 24 hours of admission.	CHRT	100%	0%																	
	Maintain 100% of adult user admitted to Unit by 9am - 9pm that have received a gate keeping assessment by the CRHT service prior to admission	CHRT	100%	0%																	
2	**LEADERSHIP, EMPOWERMENT, CULTURE & OD**																				
	Strengthen sustainability & stability of leadership roles																				
	Reduce the number of Senior Leadership Roles vacant from 1 To nil	Divisional Performance Report	1	100.00%																	
	Increasing leadership visibility, at all levels, with a purpose																				
	Numbers of areas visited by DSLT and attendance at local Tier 1 areas meeting increased from 0 To 1 per month	Divisional Performance Report	0	100%																	
	Develop an open and honest culture where staff feel empowered																				
	Increase number of staff who have undertaken coaching qualification from 7 To 12	WW& U	7	71%																	
	Strengthen communication & engagement with staff and partners (internal & external)																				
	Increase number of MH&LD Briefings per year from 8 to 12	Divisional Performance Report	8	50%																	
3	**SAFE & EFFECTIVE CARE**																				
	Reduction of incidents in relation to falls, medication errors and the deteriorating patient																				
	Reduce number of Falls resulting in harm or death from 35 to 18	QSE report	35	48%																	
	Reduction in number of medication error from 15 to 7	QSE report	15	53%																	
	Reduction in number of never events from ? To ?	QSE report	TBC																		
	Improving the recognition of safeguarding adults at risk and ensure appropriate pathway is followed																				
	Respect - increased % of staff trained from ? To ?	QSE report	TBC																		
	PICSS - increased % of staff trained from ? To ?	QSE report	TBC																		
	Reduce the number of patient restraints from 62 per month to 31	QSE report	62	50%																	
4	**INDIVIDUAL & TIMELY CARE (Strategic Lead - HoO)**																				
	Right care at the right time in the right place																				
	Reduction in number of mixed cohorting incidents to nil.	QSE report	2	100%																	
5	**ENVIRONMENT, RESOURCE & WORKFORCE (Strategic Lead: Head of P&P / HoW)**																				
	Understanding Roles, capability - skills, knowledge & practice																				
	Reduction in agency usage from £631,000 to £473,250	Divisional Performance Report	£631,000	25%																	
	Reduction in overtime usage from £84,000 To £63,000	Divisional Performance Report	£84,000	25%																	
	Sickness absent rate reduced from 9.52 To 6%	Divisional Performance Report	9.52%	37%																	
	Increase the number of starters joining the MH&LD Division from 16 WTE to 30 WTE per month	Divisional Performance Report	16	88%																	
	Decrease the number of staff leaving the MH&LD Division from 15 WTE to 7 WTE	Divisional Performance Report	15	53%																	
	Managing daily caseload and staffing incl. rostering																				
	Success rate increased from 19% to 50%	Power BI	19%	163%																	
	Average number of applicants per vacancy increased from 0.9 to 3	Power BI	1%	233%																	
	Number of nurses recruited to post increased from 5 WTE per month to 6.6 WTE	Power BI	4.5	32%																	
	Number of HCA's recruited to post increased from 4.3 WTE To 6.3 WTE per month	Power BI	4.3	46%																	
	Number of A & C recruited to post increased from 3.5 to 5.5 WTE per month	Power BI	3.5	57%																	
	Number of Medical staff recruited to post increased from 1.5 to 2.5 WTE per month	Power BI	1.5	66%																	
6	**STRATEGY, AUDIT, OUTCOMES AND ASSURANCE (HoG / HoF)**																				
	Strengthening Governance, risk and course correction (learning)																				
	Increase in the number of residents engaging with ICAN services from 1103 to 1500	ICAN report	1103	36.00%																	
	Reduce the % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health from 74.29 to 50%	Divisional Performance Report	74.29%	33.00%																	
	Reduction in Number of suicides per year capita from 11.5/100,000 to nil	TBC	11.5	100.00%																	
	Reduction in number of concerns from 28 per month to 20	QSE	27	29.00%																	
	Increase number of compliments from 16 per month to 30	QSE	16	87.00%																	

Mental Health & Learning Disabilities Divisional Improvement Plan

6th September 2022

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

Background & Aims

- There has been a number of individual past reports, Health Inspectorate Wales (HIW) reviews and significant incidents in the Division with external scrutiny.
- The Division recognises that there is always a need for constant improvement action to strengthen the safety and quality of our services.
- The primary objective of the Divisional Improvement plan is to put in place strategies that will provide a sustainable quality service as well as safe and effective person-centred care, which meets the requirements of HIW and the legislative frameworks.

Identifying the priorities

- A triangulation exercise has been undertaken to identify the priorities within the plan and to identify common themes and areas of greatest concern.
- Multiple sources of information have been used in order to triangulate findings.
- Sources of information have included, although not exhaustive, are included in the table below:

HIW reports	Concerns, complaints, patient stories	External Reports
Public Services Ombudsman reports	Legal and Risk reports	Data available from the BCU Performance Team, and Welsh Government
SUI investigations	Coroner reports	Internal audit reports
Workforce data	Behaviour and Performance management	Improvement Cymru feedback

Identifying the priorities (continued)

Confirmed the value of taking a Divisional-wide approach
Required a phased approach to delivery which prioritised short-term improvements as well as a longer-term approach that would secure embedded & sustainable change
Required an approach steeped and disciplined in improvement methodologies and strong Programme management

Informed a plan built around 6 main workstream themes :

- Fundamentals of care
- Leadership, Empowerment, Culture and OD
- Safe Care & Effective Care
- Individual & Timely Care
- Environment, Resource & Workforce
- Strategy, Audit, Outcomes & Assurance

Core Principles driving the plan

The plan reflects the principles detailed below:

- Putting the patient first
- Working together in partnership with all key stakeholders
- Builds open, honest & safe communication
- Unifies all teams on their pursuit of a common purpose
- Enables everybody to have a voice and be listened to
- Brings continuous improvement to the core of everybody's job, every day
- Empowers and enthuses teams to make challenging changes to how they work
- Reduce clinical and operational variation
- Change behaviours through learning new knowledge and consistently practicing new working desired behaviours

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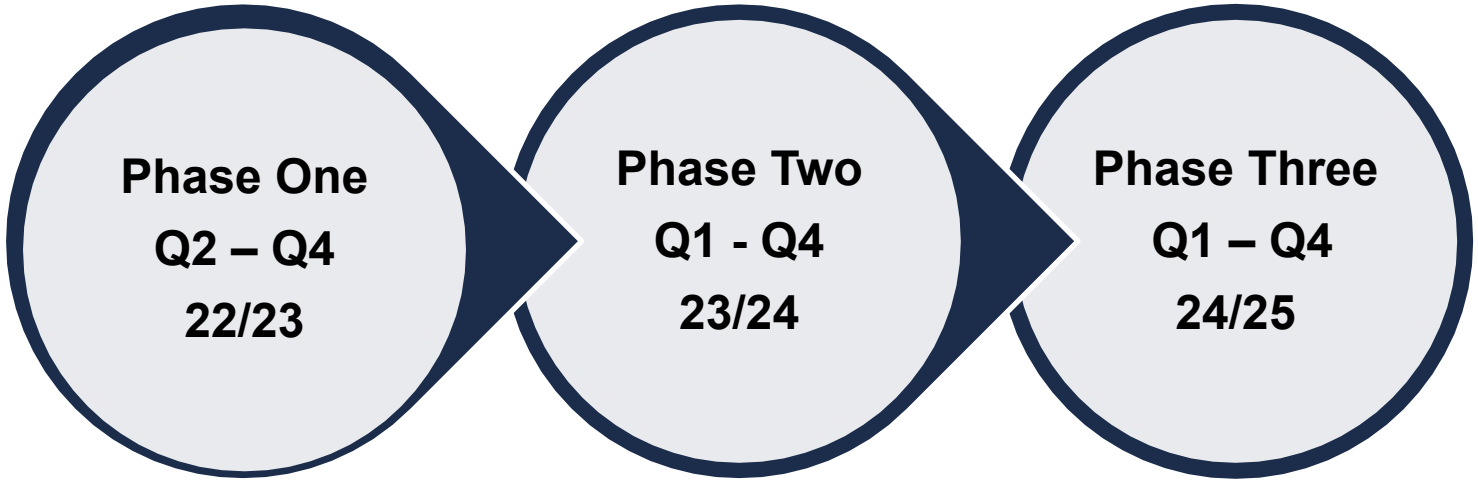
Phasing of the plan



Phase Descriptors

- **Phase 1 (Financial Year 22/23 Q2 – Q4) – Prioritised Outcomes: Safety, Quality and Capacity.** Establish and mobilise a robust, evidence based and comprehensive Divisional Improvement Plan – prioritising initiatives and actions that have the biggest impact to patient safety and fully understanding the root causes of long-standing service, people, and cultural challenges.

- **Phase 2 (Financial Year 23/24 Q1 - Q4) - Prioritised Outcomes: Access, Patient Experience, Staff Wellbeing.** Focus on a delivering and embedding the sustainable service, people and cultural plan developed in Phase 1 and developing the Phase 3 Transformation Plan.

- **Phase 3 (Financial Year 24/25 Q1 - Q4) – Prioritised Outcomes: Productivity / Efficiencies.** Deliver and embed large-scale transformation, building upon the solid foundations created in Phases 1 and 2.

Programme Oversight

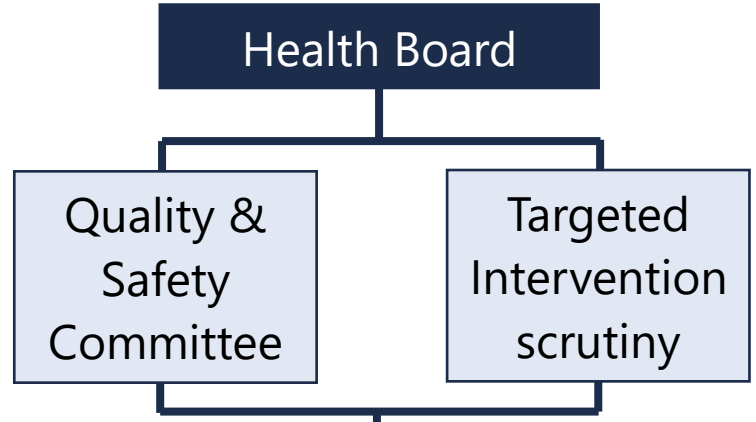
We recognised there is a need to increase 'grip and control' to support delivery and subsequent assurance.

We recognised that there was a capacity issue within the Division to help drive the required change

Additional support/ resource has been put in place to help deliver the plan

- Incorporation of Improvement Plan across all areas of the Division
- Programme Oversight monitoring meetings in place as part of programme governance framework
- Owner of the plan has been identified
- Workstream lead identified
- Reporting infrastructure aligned to the Targeted intervention structure has been applied

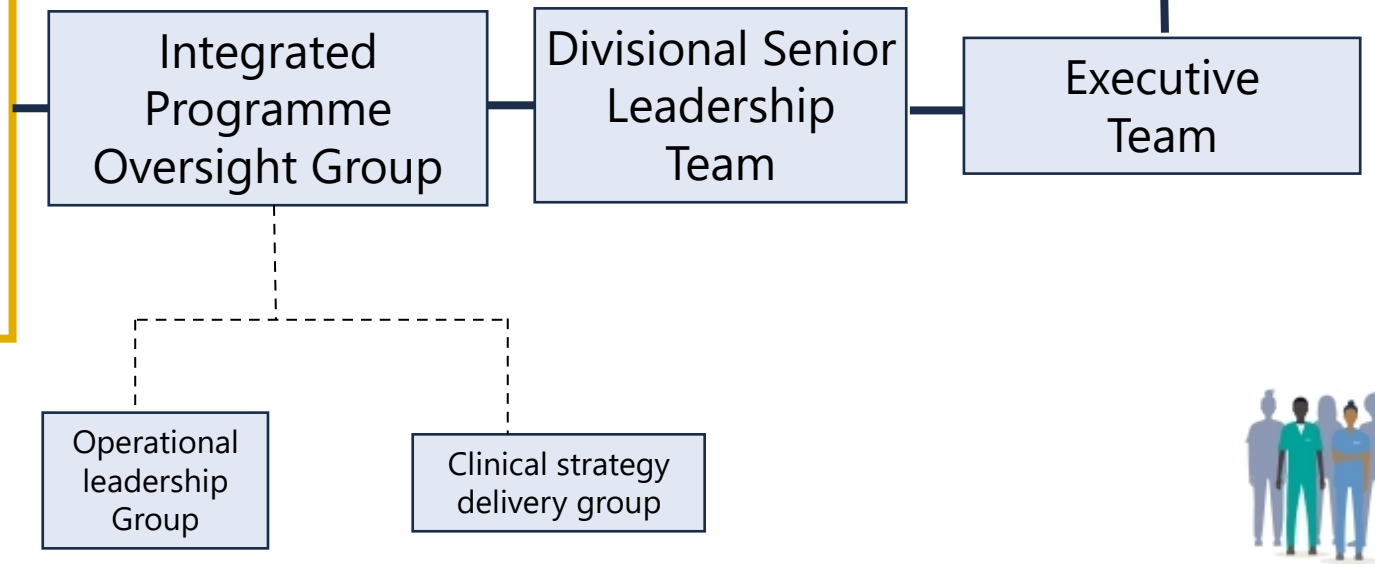
Programme Governance Framework



Project plans and programme on a page

Measurable KPIs clearly demonstrating improvement is occurring

Robust timescales, programmed and reported against



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Progress to Date

The MH&LD Division has now moved its initial plan into a format that will fully align with BCU Divisional Improvement Plans. Actions are currently underway to implement change within work streams.

- **Divisional Improvement Plan** - recommendations from inspections, reviews, reports have been scoped and included within the Plan.
- **Draft Operating Model** – an initial draft Operating Model has been completed and will be further developed with feedback from key stakeholders. Progress has been made to integrate work undertaken by the Clinical Strategy Group into the document and strengthen the Division's Model of Care.
- **Substantive capacity** – Appointment made to the Head of integrated strategy and currently supporting recruitment to the service improvement and development posts, which will drive the Divisional Improvement Plan and improvement activities.
- **Additional capacity** – operating model development, Divisional Improvement Plan, Workforce plan and Estates plan development. This will include engagement with stakeholders to develop the first two work streams. Project support recruited to support with Operating Model development, Divisional Improvement Plan, and transformational improvement priorities.

Progress to Date

- Programme Lead in place to oversee delivery of the Improvement plan
- Workstream leads identified
- Development of detailed set of deliverables and KPI’s to underpin each workstream
- Outcome measures in place

Risks

Key Risks to delivery :

- Workforce capacity within the Division to deliver the Improvement plan. This has been mitigated by the use of interim support and proactive recruitment to substantive staff anticipated by 31st October 2022.

- Information, Communications and Technologies (ICT) as an enabler to support delivery of some of the actions. Discussions held with the Divisional lead for ICT to understand implementation to support delivery.

- There is no current estates plan to support the delivery of our services, new models of care and service redesign requirements.

Teitl adroddiad: ***Report title:***	YGC IMPROVEMENT PLAN
Adrodd i: ***Report to:***	QSE
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022
Crynodeb Gweithredol: ***Executive Summary:***	The Improvement Plan is being shaped by the increasing engagement of staff on site. As a Programme of improvement work, the plan continues to be structured and actively managed under the five workstreams previously shared: ○ Back to Basics ○ Leadership, Culture & OD ○ ED, Medicine and Flow ○ Vascular and Theatres ○ Audit, Outcomes and Assurance In engagement with staff, the conversation has tended to not demarcate across the five workstreams and instead often splits into the immediate improvements needed, alongside the longer term developmental, embedding and culture work. Increasingly this is heard on site using a 'sprint' and 'marathon' analogy which staff seem to like and relate to.
Argymhellion: ***Recommendations:***	The Health Board are asked to note the progress made to date.
Arweinydd Gweithredol: ***Executive Lead:***	Gill Harris
Awdur yr Adroddiad: ***Report Author:***	Gaynor Thomason, Programme Director Clinical Safety Improvement

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐	Derbyniol *Acceptable* ☐	Rhannol *Partial* ☐	Dim Sicrwydd *No Assurance* ☐
	Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion**	

Next Steps: ***Implementation of recommendations***
Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*

Key Milestones since last Cabinet

A number of changes occurred on 1 August as a result of the Operating Model implementation and the commencement of Angela Wood as BCU Executive Director for Nursing & Midwifery. These include

- Gaynor Thomason has moved to become the improvement director for YGC and is now based on the YGC site.

- The triumvirate senior leadership structure has changed on site.
    - Director of Nursing, whilst still in Centre, has a changed portfolio of Associate Director of Nursing for the Health Community.
    - The Hospital Director of Operations, now has operational responsibility of the hospital site within the wider Health Community leadership team.
    - Within the Health Community leadership team Alyson Constantine has joined as Integrated Health Community Director of Operations.
    - An interim Director for the Health Community has been appointed and will be joining in September as a secondment.
    - An ED consultant will join the HB in September from Welsh Government to support operational medical leadership in YGC.

Development of Improvement Pathways

- A defined smaller group of high value metrics have bene devised to be consistently reported to cabinet. Where possible these will be in line with national benchmarking and will align across the North Wales USC improvement plan.

- The START model in ED is being deployed more consistently. Within this, a renewed focus upon Triage appears to be impacting positively with early data showing a shortening of triage waits. This data is being interpreted cautiously, as it is early data and we still require further improvement and embedding, but nevertheless still positive. Work is now ongoing to extend this to those times when triage times are still longer, and to embed/normalise.

- Similarly, there is some early improvement in SDEC performance. This follows strong engagement on site to evolve SDEC and maximise use. Staffing constraints mean that SDEC is currently limited to 5 day working, but this has been addressed and the site expect to extend SDEC to 7 day working in September. In the meantime process efficiency is being addressed over 5 day working to optimise the model.

- A significant amount of work has occurred since the last cabinet to improve staff engagement and inclusion within the evolution of the plan, with the senior leadership team on site now being far more in-reaching into the site for ideas and feedback. Examples include the
    - Improvement Room
    - Meetings with key professional groups
    - Increased walkabouts with deliberate discussions re improvement plan with staff

- Enhanced communication with the public has been supported by the Comms team. Material is being developed in readiness for the public information boards (which have been ordered)

- Culture. Conversations with staff since the last Cabinet have been encouraging. There is a disappointment about the contents of the HIW report, but an acceptance of it and the need for improvement. This acceptance of a need for improvement can be seen to be extending beyond ED and vascular clinical areas, which is also encouraging and being proactively supported.

This includes growing commitment on site to the challenges of a 'clinical compact'[1] as a way of contracting with professionals to address culture, performance, and collaboration.

- The increased engagement on site is resulting in the emergence of ideas on site for addressing improvement. This is shaping evolution of the improvement plan, which is a positive sign.

- Baseline workforce data has been sourced and will be used to prioritise high risk recruitment areas to ensure appropriate focus. This will include better understanding of locum utilisation.

Initial verbal feedback from the YM HIW visit describes that they were pleased to note the internal quality assurance processes and sharing of learning from YGC, and what work had been undertaken across YM to learn from YGC.

Improvement Cymru

Improvement Cymru have now committed to provide the following support,

- **Bespoke Board and Executive support**
  2-3 day (over 2-3 months) programme with Executives/ Non-Executives provided by external experts (IHI, previous CEOs, Chairs) and supported by monthly coaching where requested.

- **Leading for Improvement Programme**
  5 day (over 2-3 months) programme (plus coaching) for 35 Clinical and non-clinical leaders provided by Improvement Cymru and external experts such as IHI.

- **Improvement Coach Programme**
  2-3 day (over 2-3 months) programme for up to 10 individuals within YGC.

- **Real Time Demand and Capacity implementation**
  Coaching and support from Improvement Cymru and RTDC advisors for YGC to implement the methodology, contextualised to YGC given the current work that has taken place

Shaping of the Improvement Plan

As above, the Improvement Plan is being shaped by the increasing engagement of staff on site. This is being encouraged.

As a Programme of improvement work, the plan continues to be structured and actively managed under the five workstreams previously shared:

- Back to Basics
- Leadership, Culture & OD
- ED, Medicine and Flow
- Vascular and Theatres
- Audit, Outcomes and Assurance

In engagement with staff, the conversation has tended to not demarcate across the five workstreams and instead often splits into the immediate improvements needed, alongside the longer term developmental, embedding and culture work. Increasingly this is heard on site using a 'sprint' and 'marathon' analogy which staff seem to like and relate to.

To date there has been has been two drop-in sessions related to TI raising excellent contributions from staff. This has enabled wider discussion and greater understanding of how the improvement

[1] The Clinical Compact approach has been taken by a number of Healthcare organisations to improve engagement and ownership amongst professional staff groups. This involves contracting as individuals regarding acceptable professional behaviours and the role this has to play in minimising system stress.

journey can progress. A further series of engagement seminars with Q&A sessions are set to take place on September 5, along with a new monthly staff newsletter starting at the end of August. Signage has been placed in public areas informing the public who Glan Clwyd Hospital's clinical leaders are and encouraging feedback on patient experiences. This forms part of wider messaging promoting BCUHB values, using posters and versatile digital messaging.

Journey to Excellence

A paper is provided to cabinet outlining an approach to reporting High Level measures. The intent is that these measures provide a barometer of the YGC system improvement and align with evidence.

They also align with the multiple operational/process measures that are tracked by the SRO through the programme management team which would allow us to avoid the reporting of what is otherwise a large and unwieldy set of technical measures if used for Cabinet purposes. Instead, variances to sub-level metrics would be reported by exception alongside the high-level measures.

Safety

Triangulation of incidents and complaints is being used to ensure the outcomes agreed are improving patient experience.

All serious incidents are escalated as soon as they occur. A current incident under review relates to vascular services.

Recruitment

A large amount of work has been undertaken since the last cabinet to better understand, and then coordinate, the workforce recruitment position at YGC. There remains a lot of work to do to validate data, and to reset baseline levels in some places, but the information that is already available is helping to target efforts in recruiting to key areas at YGC.

- Reconciliation against core staffing levels has occurred to ensure key vacancies are identified and visible within the recruitment pipeline.

- Greater coordination across site for staffing vacancies mean that posts can be 'triaged' to ensure that recruitment to critical roles is prioritised.

This will continue to evolve with support from the Executive Team. It will also be discussed in the forthcoming workforce deep-dive.

In terms of some key nursing registrant & midwifery data:

Emergency Department	
Number of nursing registrant roles within funded establishment	92.7 FTE
Number of nursing registrant roles in post	64.0 FTE
Vacancies against funded establishment	28.7 FTE (31%)
- Posts interviewed and currently being on-boarded	11.9 FTE
- Posts vacancies being advertised, shortlisted or booked for interview	8.6 FTE
- Posts in recruitment cycle	20.5 FTE

Across whole of YGC	
Number of nursing registrant roles within funded establishment	839.4 FTE

Number of nursing registrant roles in post	714.3 FTE
Vacancies against funded establishment	125.1 FTE (15%)
- Posts interviewed and currently being on-boarded	61.0 FTE
- Posts vacancies being advertised, shortlisted or booked for interview	126.9 FTE
- Posts in recruitment cycle	187.9 FTE

YGC Improvement – Proposed high level measures

Background & Rationale

Version 1 of the YGC Improvement Plan contained a large number of evidence requirements and a growing number of metrics/measures.

Together, these far exceeded one hundred. These requirements and measures best serve us as operational tracking tools, used to identify early signs of the need for 'course correction' or intervention and are being used by Associate Director, supported by the Programme Manager, for that purpose.

Whilst they are as 'SMART'[2] as possible, and outcome-based where they can be, they are operationally focused in order to meet the above purpose. They would present as unwieldy and cumbersome if reported at this level to Cabinet, committee or Board.

This aligns with other feedback on performance reporting and assurance, including

- the commitment in the IMTP to develop a smaller subset of high-value outcome measures that would act as a reliable barometer of overall system health, allowing Board members to prioritise time upon their strategic leadership.

- feedback from the Institute of Healthcare Improvement in recent weeks has been that reporting on a large number of operational metrics introduces a risk of creating a quality management system that is unbalanced towards assurance.

Consequently, we propose

1. That a smaller collection of high-value metrics that relate to the concerns identified at YGC are consistently reported to cabinet, in a format that allows trends to be easily seen.

   Where possible these metrics will be those used nationally to allow benchmarking.

2. That a short summary report of the wider operational dataset referred to above is created for cabinet, limited to areas of concern requiring escalation.

3. Some additional metrics related to experience are included in the proposed list below, reflecting work already underway. These will help in terms of balance and will be brought online as soon as possible.
4. We will do more work to further develop a balance across the reporting of improvement as we move forwards with our relationship with IHI.

Proposed high level measures

[2] SMART

National 6 Goals for Urgent and Emergency Care – Goal 2

Signposting people with urgent care needs to the right place, first time

1	Number of patients signposted from YGC ED to UPCC ***Rationale:*** *reduction in ED patient volume by removing the significant number of patients who would be more optimally managed through a primary care model, rather than acute ED model.* ***Note:*** *An on-site UPCC is being planned, but not currently in place. This measure will be added once an UPCC is in place.*	Number of patients presenting to YGC ED who are [appropriately] signposted to the YGC UPCC Measure target: tbc  Increasing absolute number ✂
2	**Primary Care referrals directly to specialty** ***Rationale:*** *reduction in ED patient volume by removing the significant numbers of GP referrals which could be safely managed by allowing direct referral to specialty assessment areas rather than transiting through ED*	% of Primary Care referrals accepted directly by - Acute Medical Unit (AMU) - Ambulatory Assessment Unit (AAU) - Same Day Emergency Care (SDEC) - Surgical Assessment Unit (SAU) - Paediatric Wards Measure target: Between 50% and 75%[3] 0% 100%
3	**Reduced ED transit times** ***Rationale:*** *the various interventions to reduce footfall in ED, and to speed up onward referral/discharge/signposting, are with the intention of reducing ED transit, returning ED to a place of urgent assessment, treatment and stabilisation only.*	Average transit time from the point of triage to the point of leaving the ED department. Mean average transit time (minutes)  Time ✂

National 6 Goals for Urgent and Emergency Care – Goal 3

Clinically safe alternatives to admission to hospital

4	**Admission avoidance by maximising SDEC use** ***Rationale:*** *the purpose of SDEC is to provide an alternative to admission to hospital from ED.*	% of SDEC patients whose next stage of care is not an acute hospital admission Measure target: Above 75%[4]  0% 100%
5	**Inpatient admissions from ED that are less than 1 day length of stay** ***Rationale:*** *Some short length unscheduled care admissions from ED are appropriate, but high numbers indicate missed SDEC opportunities.*	Number of patients, with admissions originating from ED, where discharge occurs within 24 hours of transfer from ED. Excluding paediatrics, O&G, orthopaedics, oncology. Measure target: tbc  Increasing absolute number ✂

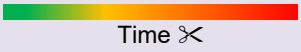
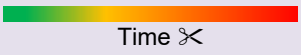
National 6 Goals for Urgent and Emergency Care – Goal 4

Rapid response in a physical or mental health crisis

6	**Ambulance handover**	Completed handover time from arrival time to ambulance release back to WAST.

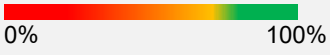
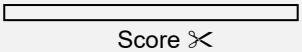
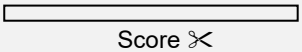
[3] This optimal target range is based upon local Executive judgement and will need to be reviewed as real data is collected.

[4] This optimal target is based upon local Executive judgement and will need to be reviewed as real data is collected.

	Rationale: *Care in ambulances on ED forecourts increases risk to the individual and to ambulance availability within the community*	a. % of ambulance handovers completed within 30 mins Measure target: Above 75%  b. Mean average handover time Measure target: Below 30 minutes  Time ✂
7	**Triage time** ***Rationale:*** *Timely triage has been a challenge historically. Slow triage increases waiting room risk and delays opportunity to utilise fast-track pathways.*	Time from ED book-in to commencement of clinical triage a. % of patients triaged within 15 mins Measure target: Above 75%  b. Mean time to triage Measure target: Below 15 minutes  Time ✂

National 6 Goals for Urgent and Emergency Care – Goal 5

Optimal hospital care and discharge practice from the point of admission

8	**Patient Experience of inpatient care** ***Rationale:*** *High volume patient experience feedback provides opportunity to add balance to our measures, to split myth and reality from a patient 'what matters' perspective, and allows drill down to specific areas and issues for targeted action.* **Note:** *A Discharge PREM is currently being designed and will be reported on as soon as launched*	Opportunity to complete a BCU Discharge PREM offered to all adult patients at the point of discharge from YGC inpatient care. a. % of adult patients who have been given the opportunity to complete the BCU Discharge PREM Measure target: Above 75%  b. Mean global Discharge PREM score Measure target: tbc  Score ✂
9	**Patient Experience of non-admitted ED care** ***Rationale:*** *High volume patient experience feedback provides opportunity to add balance to our measures, to split myth and reality from a patient 'what matters' perspective, and allows drill down to specific areas and issues for targeted action.* *This PREM will capture those who are not eligible for the Discharge PREM* **Note:** *A 'non-admitted ED care' PREM is currently being designed and will be reported on as soon as launched*	Opportunity to complete the PREM offered to all adult patients seen in ED and not admitted. c. % of adult patients who have been given the opportunity to complete the BCU Discharge PREM Measure target: Above 75%  d. Mean global PREM score Measure target: tbc  Score ✂

National 6 Goals for Urgent and Emergency Care – Goal 6

Home first approach and reduce the risk of readmission

10 **Home First**

Rationale: *Discharge to home is often inappropriately dismissed in preference for care placements, and not supported by the longer term evidence. Waits for care placements also significantly extend LOS.*

% of adult inpatients discharged to usual place of residence

Measure target: Above 80%

0% 100%

UEC Pathway: Outcome Measures and Tracjectories

Ref	Pathway	Outcome Measure	YGC Target	Links to Welsh Government Six Goals for Urgent and Emergency	Basineline (Jul-22)	Data Source		Improvement Trajectory														Comments
								#####	#####	#####	#####	#####	#####	#####	Apr-23	#####	#####	Jul-23	#####			
YGCI01	Pre Hospital	Reduced emergency attendances	10% reduction emergency attendances	UEC Goals 1, 2, 3 and 4	5183	[illegible]	Plan	5183	5183	5137	5086	5035	4985	4935	4885	4836	4788	4692	4665			month on month reduction commencing Nov-22 as new models of care come online
							Actual															
YGCI02	Emergency Department	Reduced ED journey times	average time in ED < 6hrs	UEC Goals 1, 2, 3 and 4	9.15hrs	[illegible]	Plan	9.15	8.65	8.35	8.35	8.35	8.05	8.05	7.35	7.35	7.05	6.35	6.0			step change reduction commencing Oct--22 as new models of care come online and/or embed
							Actual															
YGCI03	Assessment	Reduced >1 day LOS (emergency admissions)	40% of emergency admissions <1 day LOS	UEC Goal 3 and 4	35%	[illegible]	Plan	35%	35%	37%	37%	37%	38%	38%	38%	39%	39%	39%	40%			month on month increase commencing Nov-22 as new pathways and models of care come online
							Actual															
YGCI04	Acute Wards	Reduced >21 day LOS	<15% of bed base occupied by >21 day LOS	UEC Goal 5 and 6	17.38%	[illegible]	Plan	17.2%	17.0%	16.9%	16.8%	16.5%	16.2%	16.0%	15.8%	15.6%	15.4%	15.2%	15.0%			month on month reduction commencing Sept-22 as process and culture change embeds
							Actual															
YGCI05	Discharge	Increased discharges to usual place of residenc	85% of patients discharged to usual place of residence	UEC Goal 5 and 6	88%	[illegible]	Plan	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%			maintain or exceed target performance
							Actual															
YGCI06	Discharge	Earlier discharge to normal place of resisidnce	50% of discharges to usual place of residence <48hrs of MFD	UEC Goal 5 and 6	6%	[illegible]	Plan	6%	11%	16%	21%	26%	31%	36%	41%	46%	50%	50%	50%			5% increase month on month, with sustianed performance from Jun-23
							Actual															

Record keeping

Home first approach and reduce the risk of readmission

11 Record audit outcomes

Rationale: *There have been a range of records related concerns at YGC.*

% of doctor records rated green in the audit

Measure target: Above 90%

0% 100%

% of nursing records (including falls/HAPU risk assessments) rated green

Measure target: Above 90%

0% 100%

% of vascular records rated green for consent

Measure target: Above 90%

0% 100%

12 Never Events & SI's

Rationale: *There have been a number of never event and adverse incidents reported at YGC (and in vascular pan BCU), and we would expect to see those reduce as part of improvement.*

Number of YGC Never Events and Incidents graded as 'serious'

Measure target: 0

Number of events ✂

Number of vascular Never Events and Incidents graded as 'serious' (including breaches of complex surgery double operating requirements), across BCU

Measure target: 0

Number of events ✂

Recruitment

13 Recruitment

Rationale: *There are vacancies in YGC contributing to the challenges on site. Addressing this is important through a combination of effective recruitment processes, and a coordinated approach to priority vacancies on site. Non-core staffing spend has increased as a result and further fuelling sustainability and delivery issues on the site.*

Number of the top 20 priority vacancies on site that either have open recruitment adverts, or are progressing through post-advert appointment stages.

Measure target: 18+

0 20

% of pay spend that is non-core

Measure target: 4%

Teitl adroddiad: ***Report title:***	North Wales Vascular Service Update			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This paper updates Quality, Safety and Experience (QSE) Committe on progress in delivery the improvements in north Wales vascular service. In addtion the paper summarises key operational and planning issues relevant to the service.			
Argymhellion: ***Recommendations:***	The Committee is asked to Note the progress in delivery of the Vascular Improvement Plan and commencement of work to align the Improvement methodology with the wider Targeted Intervention framework approach. Note that the Board has received Escalations from the Vascular Quality Panel and that immediate make safes, introduced on July 8th 2022 remain in place. Note the current contingency planning through an Emergency Preparedness, Resilience and Response (EPRR) response to the short and medium term fragility of the north Wales vascular service. Note the development of an updated engagement plan to ensure partners, staff and patients are informed of current issues within the service. Note the review of vascular services by Healthcare Inspectorate Wales to take place over the coming weeks			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Dr Nick Lyons, Executive Medical Director			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth

	High level of confidence/evidence in delivery of existing mechanisms/objectives	*General confidence / evidence in delivery of existing mechanisms / objectives*	*Some confidence / evidence in delivery of existing mechanisms / objectives*	*No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The vascular service is a Service Requiring Significant Improvement under the HIW NHS escalation process The Health Board continues to work closely with professional regulators including the General Medical Council (GMC).
Yn unol â WP7, a oedd EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA been identified as necessary and undertaken?***	An EqIA may be required as part of the examination of options within any contingency planning.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	An SEIA may be required as part of the examination of options within any contingency planning. .
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The Corporate Risk Register (CRR) as well as the EPRR risks are continually updated to reflect the current situation
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The increased costs of dual consultant operating and agency doctor costs are currently being assessed.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The current fragility of the service has an impact on the workforce in both hub and spoke models and wellbeing support for staff is being offered.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	None at this time

Feedback, response, and follow up summary following consultation	
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	
List of Appendices: ***Appendix 1*** ***Vascular Improvement Plan*** ***Appendix 2*** ***HIW Vascular Local review Terms of Reference***	

North Wales Vascular Service Update

Quality, Safety and Experience Committee Tuesday 6th September 2022

Introduction

The Health Board implemented a hub and spoke model for delivery of vascular services in north Wales in April 2019 thereby implementing a model for service delivery that was endorsed by external review. This service includes the provision of some specialist services in Liverpool and Alder Hey hospitals.
An Invited Service Review by the Royal College of Surgeons (RCS) was commissioned by the Board in 2020 to review the quality of the new service, the first report from this review being received by the Health Board in March 2021 and the second report being received in February 2022. In response to the second report the Board convened a Vascular Quality Panel (VQP) with an external chair. The various improvement plans relating to vascular were integrated into a single Vascular Improvement Plan (VIP) in November 22 and a strengthened Vascular Steering Group was established at that time with lay and Community Health Council

That panel first met in April 2022 with weekly escalation reports as necessary to the Executive Medical Director (EMD), which then inform the Vascular Improvement Plan.

On 8 July 2022 the Chair of the VQP raised safety concerns in relation to the management of aortic patients following the completion of a review of 11 patients' notes. The EMD received 3 recommendations for immediate implementation including the requirement for dual consultant operating for some more complex procedures and the involvement of regional specialist centre in multidisciplinary (MDT) planning of the care of those patients.

A review of these concerns by the Medical Director noted that HM Coroner (HMC) may not have been fully informed of the circumstances surrounding the deaths of 4 patients and further information was shared with HMC on 29 July 22 and duty of candour discussions began with 4 families.

In the Terms of Reference (ToR) of the VQP it was agreed that a final report would be provided in order that a triangulated overview of the 47 cases would be published. A route for escalation of any more urgent issues was agreed from the Independent Chair to the EMD. The frequency of these escalations led the EMD to discuss with the Independent Chair on 3rd August 22 whether consideration should be given to publication of an interim report. It was agreed instead that an escalation report would be sent to the EMD in order that the regular escalations came within formal governance processes.

Current Situation

The escalation letter

The escalation letter provided detail on the background and working practices of the panel and laid out the high-level escalation themes.

Several of the themes had already been recognised and work started to address them in 2021 in response to the RCS reports and learning from incidents within the service

1. Poor standards of documentation:

A weekly audit of clinical notes in both hub and spoke sites was introduced in February 2022 and weekly actions identified to improve the quality of note keeping, including consent and recording of MDT discussions

2. Consent standard:

In addition to the audit approach, training sessions on consent have been delivered to all medical staff in March and April 22 and a workshop with General Medical Council (GMC) and Healthcare Inspectorate Wales (HIW) held that included detailed discussion on consent and the concept of shared decision making

3. MDT discussions

Liverpool University Hospital Foundation Trust (LUHFT) have supported decision making through a Memorandum of Understanding (MoU) agreed in March 22.

The management of pain and the need for a more holistic and compassionate approach to the care of patients had been recognised prior to the VQP reports, but the detail within the more recent findings allow a more targeted approach and this will now inform the second patient experience survey which will shortly commence.

Progress continues to be made in the progressing actions in the wider Vascular Improvement Plan (VIP) and it is being updated to ensure that it is in the same style as the wider Ysbyty Glan Clwyd (YGC) improvement plan and to ensure that the outcome measures are clearly defined.

Importantly it is also being updated to embrace the same improvement methodology as the wider YGC improvement plan.

The Committee is asked to note progress in delivery of the Vascular Improvement Plan and commencement of work to align the Improvement methodology with the wider Targeted Intervention framework approach.

The Committee is asked to note that the Board has received Escalations from the Vascular Quality Panel and that immediate make safes, introduced on July 8th 2022 remain in place.

Contingency Planning

The requirement for dual consultant operating for aortic cases has caused significant pressures on the consultant rota.

A new consultant who was due to start in August 22 has now delayed his start date to summer 23.

In July 22 an enhanced level of support for aortic surgery from LUHFT was negotiated and this has resulted in the Liverpool service providing out-of-hours cover on 2 occasions:

- On July 19th the aortic on-call was supported by Liverpool. No patients needed to be transferred on that occasion
- On August 21st the aortic on-call was supported by Liverpool. One patient was transferred to Liverpool for assessment.

Due to capacity within NW England further resilience for contingency planning from NHS England was agreed with Royal Stoke University Hospitals NHS Trust in the week commencing 25th July and for this potential dual support for contingency planning to continue to the end of September.

In July 22 a more structured approach to the contingency planning was adopted in an EPRR model with a Gold strategic meeting taking place each Tuesday. This is supported by planning, commissioning, finance, workforce as well as by the vascular operational team.

The Commitee is asked to note the current contingency planning through an Emergency Preparedness, Resilience and Response (EPRR) response to the short and medium term fragility of the north Wales vascular service.

Engagement plan

There is already extensive involvement and leadership in communications and engagement.

The increasing complexity of the vascular work and contingency planning mean that this work should now be summarised in an engagement plan.

It will also continue to be important to ensure we keep our staff and patients up-to-date.

The Committee is asked to note the development of an updated engagement and communications plan to ensure partners, staff and patients are informed of the current issues within the service.

Healthcare Inspectorate Wales

The Health Board received notification on 19th August 22 that plan to carry out a local review of vascular services over the coming weeks. The Terms of Reference (ToR) of that review are included in Appendix 2 of this report.

The Committee is asked to note the review of vascular services by Healthcare Inspectorate Wales to take place over the coming weeks

Financial Implications

The immediate costs of dual consultant operating and addressing capacity within the vascular operational team and the associate improvement work is currently being finalised but is expected to be within current funding plans, recognising that the full year costs of increased staffing within the Integrated Medium Term Plan (IMTP) will not be committed.

Risk Management

The Corporate Risk Register (CRR) as well as the EPRR risks are continually updated to reflect the current situation.

Betsi Cadwaladr University Health Board (BCUHB) – Local Review of the Vascular Service, Betsi Cadwaladr University Health Board.

Terms of Reference

Why are we doing this work?

Healthcare Inspectorate Wales's (HIW) purpose is to check that healthcare services are provided in a way which maximises the health and wellbeing of people.

In line with its NHS service of concern process, in February 2022 HIW designated the Vascular Services at Betsi Cadwaladr University Health Board (the 'health board') as a Service Requiring Significant Improvement (SRSI). This was in response to the Royal College of Surgeons (RCOS) Clinical Record Review Report, published on 20 January 2022, which identified a number of concerns that indicated a risk to patient safety when using the health board's vascular services.

These concerns relate to:

- The quality of clinical care
- Risks to patient safety
- Poor Multidisciplinary Team (MDT) working
- Poor documentation and record keeping.

The RCOS report noted a number of recommendations that the health board needs to address in order to improve the quality of care and service provided to ensure the safety of patients.

As a consequence of the SRSI designation, HIW has decided to undertake a review within the health board's vascular services, which will examine the progress made by the health board in relation to each recommendation highlighted in the RCOS report, to gain assurances on patient safety and the quality of care being provided.

The outcome of this review will enable HIW to consider whether the health board's vascular services can be de-escalated as a SRSI or to identify further actions for improvement.

Scope and Methodology

This review will focus on the RCOS review report and will assess the progress made by the health board in addressing the review recommendations to maintain patient safety and quality of care. The review will consider the actions implemented, improvements made, and whether the measures taken to address the recommendations ensure safe care of good quality to patients, and whether this is sustainable.

The key question that this review will seek to answer in relation to the vascular services is:

Do the current arrangements in place within the health board's vascular services support the delivery of quality care, which is safe, timely and effective?

In answering this question, we will consider the following key lines of enquiry:

- What governance arrangements are in place at the health board to monitor the ongoing response to the RCOS findings and recommendations, and are they effective?
- Is there evidence that the urgent concerns identified by the RCOS have been or are being addressed effectively?
- Is there evidence to support whether the actions taken to maintain patient safety and the quality of care are effective, are sustainable, and will aid service improvement?

In addition to the review's primary focus on the health board's response to the RCOS recommendations, we will also engage with the Vascular Quality Panel (VQP) as part of this process to help inform the review and its findings. Furthermore, we will engage with the RCOS in light of their commitment to follow up with the health board to gain assurance that timely action has been taken to address their recommendations relating to patient safety.

To assess the areas detailed above, the review will examine a sample of individual cases of patients who have accessed the health board's vascular services. Additionally, to gather further evidence as part of our review, we will carry out the following fieldwork:

- Interviews with a range of health board staff
- Interviews with some Board members of the health board
- Engagement/survey relevant staff members to ensure their views and experiences are captured and considered

- We will seek to capture the views and experiences of patients, including individuals selected as part of our case review
- Document review and analysis of a range of corporate and operational information and data, including committee minutes and papers
- We will engage with other stakeholder organisations, where necessary, throughout our review.

Timescales

The table below includes estimated timescales for the review:

Activity	Timescales
Fieldwork planning and document review	August -September 2022
Fieldwork	September – October 2022
Report Publication	December 2022 -January 2023

Analysis and reporting

Throughout the review fieldwork phase, the review team will give immediate feedback if any issues arise which represent an immediate risk to patient safety.

The review will conclude with the publication of a report that will set out the key themes and recommendations identified from our work. Any information provided by staff during the fieldwork will not be directly attributed to them in the report.

The health board will be provided with a copy of the draft report to comment on factual accuracy and will receive a copy of the final report prior to its publication.

If areas for improvement are identified, the health board will be required to complete an improvement plan, which should detail how the relevant services will address the findings set out in the report. Following review, any improvement plan will be published on HIW's website alongside the report.

If required, we will use our service of concern process to identify and escalate concerns, to support any necessary improvement or learning for the health board.

Personal data

This review forms part of HIW's work to provide independent assurance on the quality and safety of healthcare services in Wales. The Health and Social Care (Community Health and Standards) Act 2003 (Part II, Chapter 4) gives HIW the power to carry out inspections, reviews and investigations of the NHS or services provided for the NHS.

These terms of reference set out our intended approach to the review.

Where we process personal data, this is in accordance with data protection legislation, including the Data Protection Act 2018 and the General Data Protection Regulations. Further information is set out in HIW's privacy notice which can be found on our website https://hiw.org.uk/privacy-policy.

Teitl adroddiad: ***Report title:***	Quality & Performance Report to 31st July 2022			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022			
Crynodeb Gweithredol: ***Executive Summary:***	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 summary of the report is now included within the Executive Summary pages of the Quality and Performance Report and demonstrates the work related to the key measures contained within the 2022-23 National Performance Framework. This framework has been revised to provide performance measures including Ministerial Priority Measures under the Quadruple Aims set out in A Healthier Wales. The structure of the report follows the sub-chapter headings within the Quadruple Aims. Following feedback from members of the Board, the trend arrows have been replaced with rolling 12 month trend charts which better illustrate past performance and direction of travel of performance.			
Argymhellion: ***Recommendations:***	The Quality, Safety and Experience Committee is asked to scrutinise the report and to advise whether any areas should be escalated for consideration by the Board.			
Arweinydd Gweithredol: ***Executive Lead:***	Sue Hill Executive Director of Finance			
Awdur yr Adroddiad: ***Report Author:***	David Vaughan Head of Performance Assurance			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

	delivery of existing mechanisms/objectives	*existing mechanisms / objectives*	*existing mechanisms / objectives*	

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*** There are a number of under-performing key areas across the Health Board with limited evidence and assurance that improvements will be made and/or sustained – hence the partial assurance. **Steps to improve this rating:** We will continue focus on improving performance reporting and workflows, which includes supporting leads and services to improve the connection between correcting actions, plans and improvements – to benefit both our local population health and well-being and that of our workforce.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	The performance measures included in this report are from the NHS Wales Performance Framework 2022-23.
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This report will be available to the public once published for Quality, Safety and Experience Committee
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo *N* The Report has not been Equality Impact Assessed as it is reporting on actual performance.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *N* The Report has not been assessed for its Socio-economic Impact as it is reporting on actual performance
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)***	The pandemic has produced a number of risks to the delivery of care across the healthcare system
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within the annual plan will have direct and indirect impact on the financial recovery plan of the Board.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	The delivery of the performance indicators contained within our annual plan will have direct and indirect impact on our current and future workforce.

Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	This report has been reviewed in parts (narratives) by senior leads across the Health Board and relevant Directors. And the full report has been reviewed by the report author. There is a specific session in the Board development workshop on 20th September 2022 to provide further opportunity to discuss and agree the further iterations of the format of the report.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	There are several Corporate Risk Register and BAF risks relating to this report and committee. **See appendix A.** This QP report provides an opportunity for areas of under-performance to be identified and subsequent actions developed to make sustained improvement.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations:*** *Continued focus on any areas of under-performance where assurance isn't of sufficient quality to believe performance is or will improve as described.*	
Rhestr o Atodiadau: ***List of Appendices:*** *A: QSE Links to CRR and/or BAF risks*	

Appendix A: QSE Links to CRR and/or BAF risks (brief summaries of text – see live documents for full descriptions)

CRR	BAF	QSE
CRR22-23: inability to deliver safe, timely and effective care	1.1: consistent failure to provide safe care at YGC 1.2: risk to provision of poor standards of care to population across North Wales 1.3: ineffective management of unscheduled care demand and capacity 1.4: consistent failure to meet performance targets, resulting in patient care and outcomes 1.5: lack of capacity to deliver planned care 1.7: significant delays in medically fit for discharge due to reduced social care resources	Chapter 3: Motivated and sustainable workforce measures declining
CRR21-17: Timely assessment, treatment and discharge of young people across Child and Adolescent Mental Health Services	1.6: instability of Mental Health Leadership Model 1.8: Mental Health service's ineffective and safe delivery	Chapter 2a: Child and Adolescent Mental Health Services consistently reporting a number of key performance measures well below expected target levels
CRR21-18, -19: Capacity issues impacting on Infection Prevention and Control services, and medical devices potentially not being decontaminated	4.1: Health Board failure to provide safe systems of delivery (in accordance with H&S at Work Act 1974), leading to significant risk of avoidable harm to patients and workforce	Chapter 2c: Hospital Infection Control, and increasing COVID onset within hospital and increasing deaths contributed to sepsis, and; Chapter 4a: Clinically Effective Prescribing – performance measures showing a trend declining position
CRR21-13: Nursing staffing levels impact on service continuity and care	Related to most if not all. But with a specific link to – 2.1: Failure to attract or retain sufficient staff	Chapter 3: Motivated and sustainable workforce measures declining, and indirect link to – Chapter 5: Incidents and Complaints, e.g. increasing complaints

Quality & Performance Report

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

Quality, Safety & Experience Committee

Data up to 31st July 2022
Presented on 6th September 2022

About this Report

About this Report

Welsh Government has advised Quality, Safety and Experience Committees to continue to monitor performance in line with the measures included in the 2022-23 NHS Wales Performance Framework published in July 2022. The Report is structured according to the sub-chapters of the Quadruple Aims as presented in A Healthier Wales.

Report Structure

This report is in a state of transition as we amend it to reflect the new NHS Wales Performance Framework for 2022-23. There are new measures where data wasn't previously collected – we are working on getting this into the next report.

Due to particular meeting schedules and report production timelines it hasn't been possible to have the very latest data (to July 31st 2022) for all measures.

This 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.

Performance Monitoring

Narratives are provided on groups of red rated narratives.

As the NHS Wales Performance Framework for 2022-23 was published in the latter half of July 2022, it has not been possible to adapt this report fully to reflect the new framework in time for this meeting (September 2022)

As part of phase two of the IQPR (Integrated Quality and Performance Report) project, this report will be moved onto Power BI and utilise Microsoft 365 applications.

Ongoing development of the Report

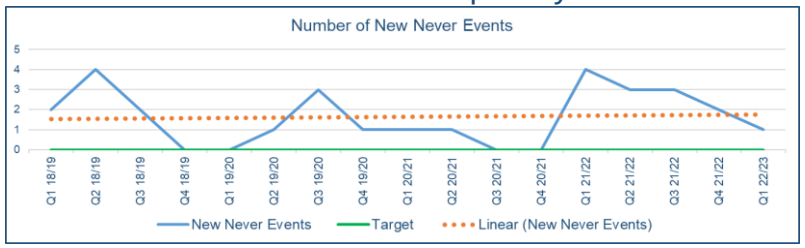
Publication of the Quality and Performance Report will continue whilst the Quality, Safety and Experience Committee transitions over to the new Integrated Quality and Performance Report (IQPR).

In the meantime, following feedback from Board members, some changes have been made to the Q&P Report. These are as follows:-

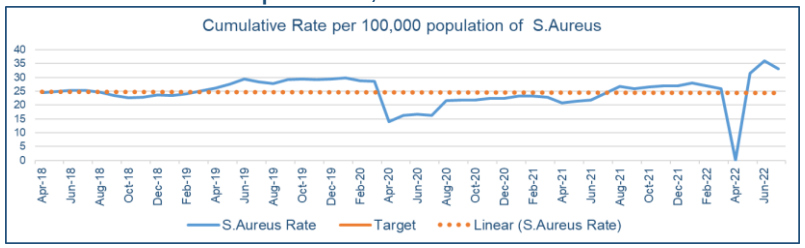
- The structure of the Executive Summary – to improve clarity of performance position.
- Images have been removed from the report to reduce the size of the report.
- RAG rated trend arrows have been replaced with 12 month trend infographics to reduce confusion regarding the direction of performance.

Summary Dashboard

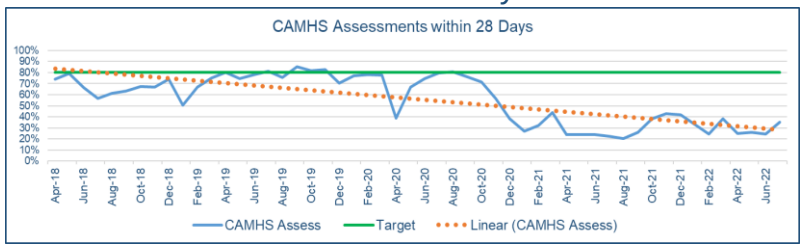
Number of New Never Events: Apr-May 2022 **1**



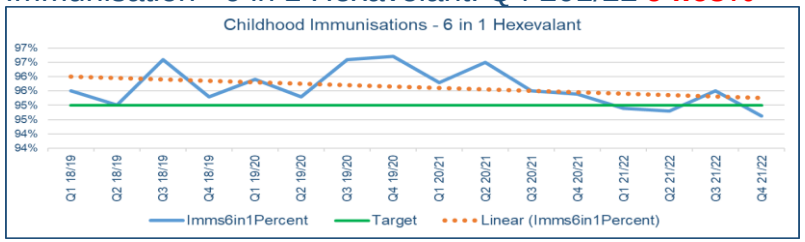
Cumulative Rate per 100,000 S.Aureus: **33.17***



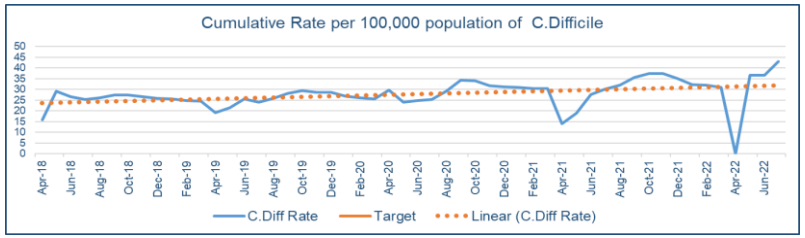
CAMHS – Assessed within 28 Days: **35.10%***



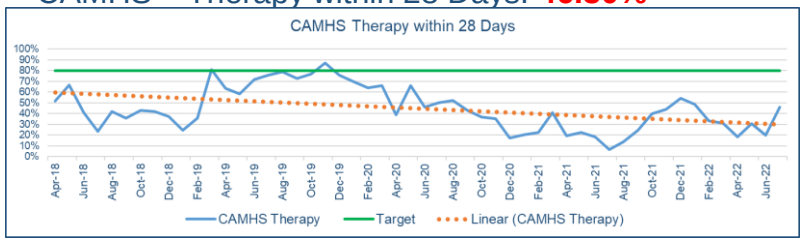
Immunisation - 6 in 1 Hexavelant: Q4 201/22 **94.63%**



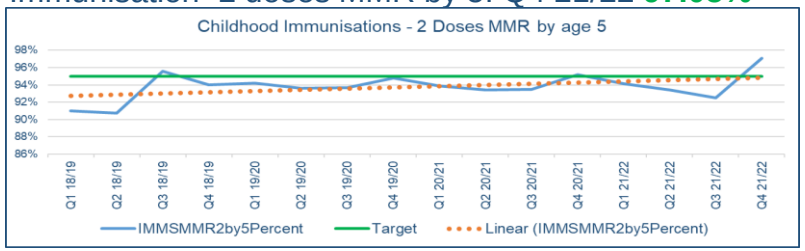
Cumulative Rate per 100,000 C.Difficile: **42.96***



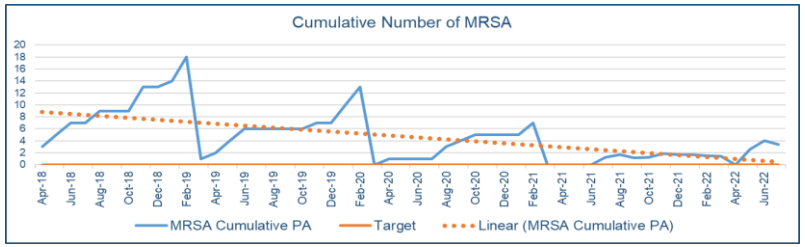
CAMHS – Therapy within 28 Days: **46.30%***



Immunisation- 2 doses MMR by 5: Q4 21/22 **97.05%**

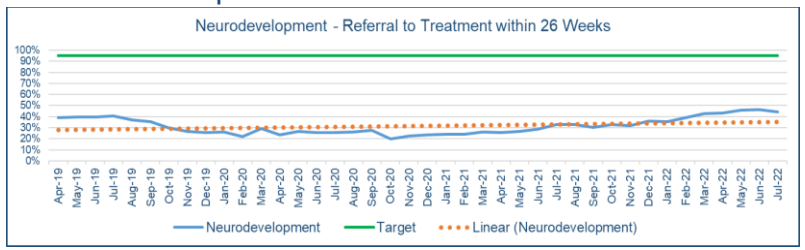


Cumulative Number of MRSA: **3.4***

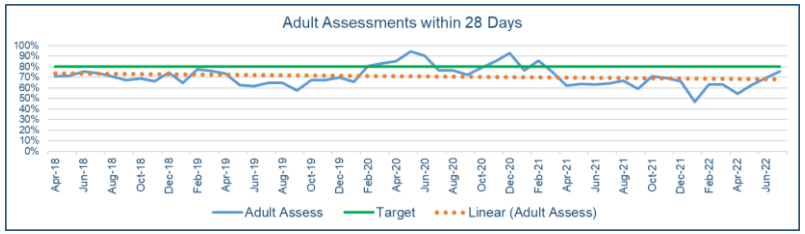


Cumulative rate resets on the 1st of April each year

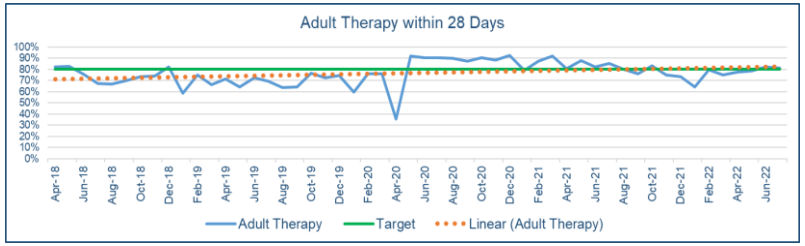
Neurodevelopment within 26 Weeks: **44.17%**



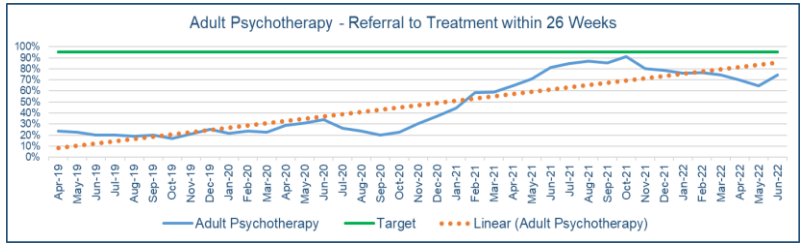
Adult MH Assessed within 28 Days: **75.20%***



Adult MH Therapy within 28 Days: **81.20%***



Adult Psychotherapy within 26 Weeks: **74.6%***



**data reported 1 month in arrears or quarterly reported*

Executive Summary

Improving Position	Static Position	Declining Position
• % of babies who are exclusively breastfed at 10 days old – improved by just under 2% 2017-21 • Both indicators of smoking (report smoking and make an attempt to quit via services) show improving positions over the past year • % of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes nearly doubled (12.5% to 22.6%) Q1 to Q4 2021/22 • % of patients waiting less than 28 days for a first appointment for Specialist Child and Adolescent Mental Health Service improved for last three months to 100% (caution small numbers though) • The last three months, particularly July, have seen the reverse of a four month declining position in % of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Service for under 18 years • % of children and young people waiting less than 26 weeks to start an Attention Deficit Hyperactivity Disorder or Autistic Spectrum Disorders neurodevelopment assessment has steadily improved over the last 12 months from 33.1% to 44.2% • % of Mental Health assessments undertaken within 28 days from the date of receipt of referral for adults aged 18 years+ has improved month-on-month for last three months (54.5% to 75.5%)	• Both substance misuse measures over the latest three reported quarters (Q2 to Q4 2021/22) indicate that alcohol misuse is very static • Both vaccinations (hexavalent 6 in 1, and MMR) in children have been above or very close to targets for the last two years • Rate of hospital admission with any mention of intentional self-harm (children 10-24 years) per 1000 population relatively static for last four years • % Mental Health assessments undertaken within 28 days of referral, whilst still well below target, has been reasonably consistent between 24.3% to 38% over the last six months • % of Health Board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years has been above target (90%) for all but one (89.2%) month in the last 12 • Both adult psychiatric measures have been at 100% since reported from August 2021 to June 2022 • % of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Service for adults aged 18 years+ has been fairly static over the past 12 months with 11 between 73.5% to 83.2% and both last two months above 80% target • Across all bacteraemias – both numbers and rates – measures remain fairly static and BCUHB doesn't appear to be an outlier compared to other Health Boards • Incidents also remain low and stable • Mortality, whilst not increasing remains a concern with the Medical Examiner Service reviewing all acute site deaths independently	• % of patients (aged 12 years and over) with diabetes achieving all three treatment targets in the preceding 15 months reduced from 29.% to 25.7% (2020/21 to 2021/22) • % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health has declined from 87.1% Aug 2021 to 74.6% (June 2022), although that was a 10% improvement on May 2022 • % of Health Board residents in receipt of secondary Mental Health services who have a valid care and treatment plan for adults 18 year+ steadily declined over last 12 months from 90.8% (90% target) to 81.7% (July 2022) • % of confirmed COVID-19 cases within hospital which had a definite or a probable hospital onset of COVID-19 show an increase compared to the same month last year (new measure for 2022/23) • Both measures of staff engagement (overall staff engagement score, and % of staff who report that their line manager takes a positive interest in their health and wellbeing) have shown a slight decline in 2019/20 to 2020/21 • All four measures (overall) of clinically effective prescribing showed a declining position quarter-on-quarter throughout 2021/22, but with a recent improvement across three of four in Q1 of 2022/23 • Complaints responded to in a timely manner has been trending downwards for nine months now, since September 2021 (68%) to June 2022 (30%) • Sepsis remains a concern, with the % of deaths contributed to by sepsis rising from 5% in January to 20% in June 2022

Chapter 1

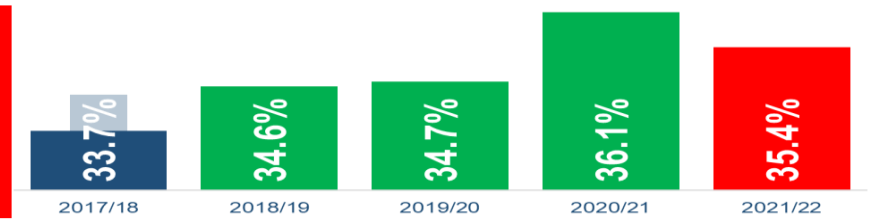
Quadruple Aim 1:

People in Wales have improved health and well-being with better prevention and self-management

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

- 1a: Weight Management
- 1b: Smoking

Measures: Weight Management

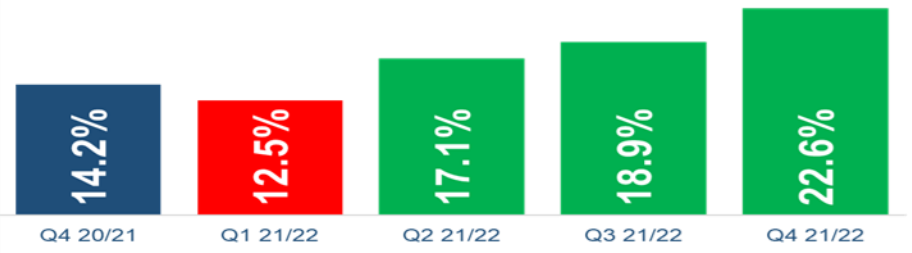
Committee	Period	Measure	Target	Actual	Trend
QSE		Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All Wales Weight Management Pathway	Improve Annually	New Measure - Awaiting Data	
QSE	2021/22	Percentage of babies who are exclusively breastfed at 10 days old	Improve Annually	35.4%	

Measures: Smoking

Committee	Period	Measure	Target	Actual	Trend
QSE	2021/22	Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally	Improve Annually	13.4%	
QSE	Q4 21/22	Percentage of adult smokers who make a quit attempt via smoking cessation services	5%	4.07%	

- 1c: Diabetes

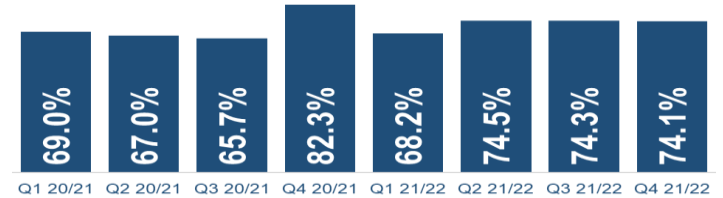
Measures: Diabetes

Committee	Period	Measure	Target	Actual	Trend (Quarterly)
QSE	Q4 21/22	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	Improve Qu'ly	22.6%	

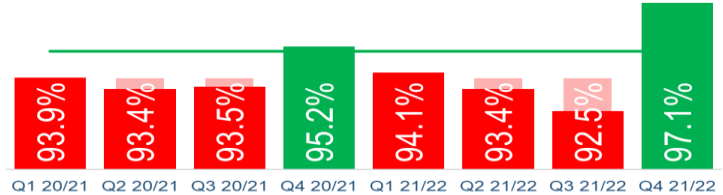
					Trend (Annual)
QSE	2021/22	Percentage of patients (aged 12 years and over) with diabetes achieving all three treatment targets in the preceding 15 months	1% annual increase from 2020/21	25.7%	

- 1d: Substance Misuse
- 1e: Vaccinations

Measures: Substance Misuse

Committee	Period	Measure	Target	Actual	Trend
QSE	Q4 21/22	European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales (episode based)	Improve Annually	373.9	
QSE	Q4 21/22	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	Improve Annually	74.1%	

Measures: Vaccinations

Committee	Period	Measure	Target	Actual	Trend
QSE	Q4 21/22	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	94.6%	
QSE	Q4 21/22	Percentage of children who received 2 doses of the MMR vaccine by age 5	95%	97.1%	
QSE		Percentage uptake of autumn 2022 booster dose of the COVID-19 vaccinations in all eligible Wales residents by health board	TBC		**New Measure - Awaiting Data**
QSE		Percentage uptake of 2022-23 influenza vaccination in all eligible Wales residents by health board	TBC		**New Measure - Awaiting Data**

Chapter 2

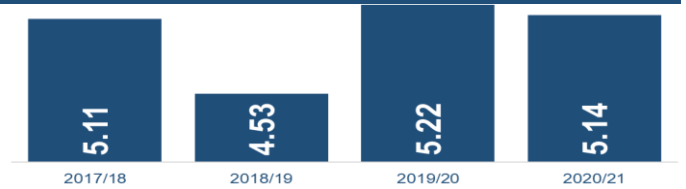
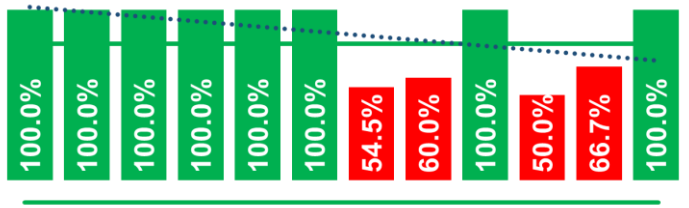
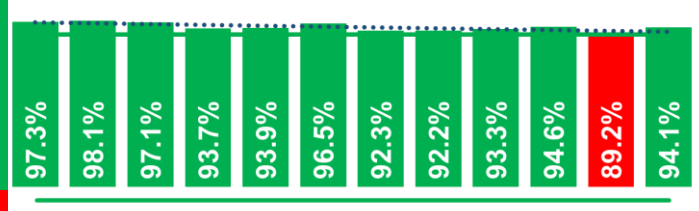
Quadruple Aim 2:

People in Wales have better quality and more accessible health and social care services, enabled by digital and supported by engagement

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

- 2a: Child and Adolescent Mental Health Services (CAMHS)

Measures: Children and Adolescent Mental Health Services

Committee	Period	Measure	Target	Actual	Trend
QSE	2020/21	Rate of hospital admissions with any mention of intentional self-harm for children and young people (aged 10-24 years) per 1,000 population	Annual Reduction	5.14	
QSE	Jul 22	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	80%	100.0%	
QSE	Jul 22	Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for people aged under 18 years	80%	35.1%	
QSE	Jul 22	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged under 18 years	80%	46.3%	
QSE	Jul 22	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for people aged under 18 years	90%	94.1%	
QSE	Jul 22	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	44.2%	

Narrative 1: Child and Adolescent Mental Health Services

Why we are where we are

End July performance against WG targets: 100% referred to CAMHS waited under 28 days for initial appointment; MHM Part 1a – 34% 1b - 46% MHM Part 2 94%. Position against mental health measure a known risk. Focus on improvement plan reduction on those waiting under 28 days. Off target against trajectory due to:

- Increase demand for mental health assessment by 6% compared to 2021/22
- Reduction in core capacity due to sickness absence and staff turnover
- Reduced uptake of private provider assessments during Q1

What we are doing about it

- Meeting to be arranged September to review reporting arrangements for young people admitted due to self harm with Informatics and Adult Mental Health Services
- Increased monitoring of private provider uptake
- Monitoring of performance against improvement trajectory and recovery planning is ongoing across all teams through the established Regional CAMHS Performance Delivery Group with escalation to Assistant Area Directors via Strategic Improvement & Development Group for oversight.
- A Performance Management Framework is being developed to ensure increased clarity of KPIs, responsibilities and accountability through Access Work Stream of TI
- Recruitment to posts identified in 2022/23 funding bids has commenced to support early intervention and prevention services to improve the early help offer within schools and primary care, manage demand into specialist services and increase capacity within core services

When we expect to be back on track

- Trajectories and recovery plans for 2022/23 have been developed with a plan to reduce total numbers waiting over 28 days prior to the end of March 2023 across all areas to support delivery of MHM Part 1 targets by year end.

What are the risks and mitigations to this (getting back on track)?

- Delays in recruitment are being supported by the PMO to ensure posts are advertised in a timely manner and promoted through Just-R recruitment campaign and social media
- Increased demands on services in terms of referrals received and acuity is monitored in weekly performance meetings in local areas to ensure that escalations are made through TI Access Work Stream and area teams
- Increased sickness absence, monitored on a weekly basis with a view to adjusting capacity across area teams.

Narrative 2: Neurodevelopment (ND)

Why we are where we are

End July performance against WG targets: 45% waiting within target to start a ND assessment. This is affected by:

- The gap between core capacity and demand is significant and affected by staff turnover, recruitment of skilled workforce, and clinical accommodation availability.
- The need to redesign and refocus the service to ensure it is needs led and provides timely, consistent and supportive services to children and their families.

What we are doing about it

- Development and implementation of a service improvement and development plan which is in progress; funding will be essential to make the impact required.
- A ND Programme Manager starts in September and recruitment is underway for a Transformational Clinical Lead
- Development of an agreed model of care for the service, which will include co-production and testing models to ensure they meet needs
- Work on cross cutting priorities to include workforce strategy, improved data collection and use of digital opportunities.
- Use of an external provider to undertake assessments. This contract is extended to end of March 2023 to ensure maintenance of the improvements made so far with the waiting list. The requirement to use further external providers going forward remains likely in order to meet demand, although this does require careful consideration due to some unintended consequences we are now seeing. Although the areas are now beginning to send some referrals of 26 weeks and less to the external provider, we are now reviewing the waiting list to ensure equity of access i.e. for those with welsh language requirements, or children with complex needs who do not always meet the provider's referral criteria.

When we expect to be back on track

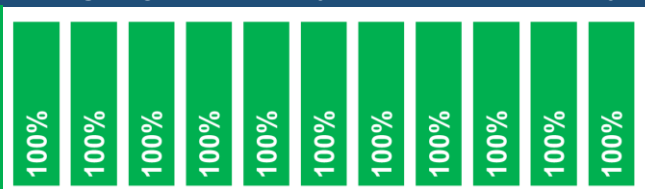
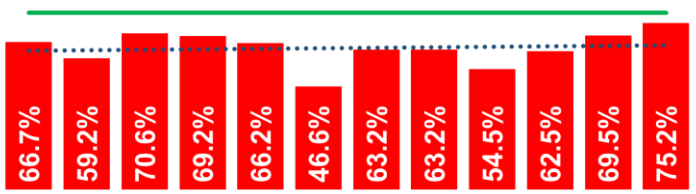
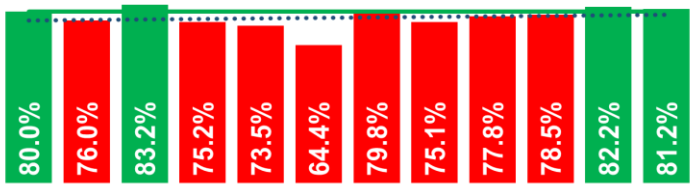
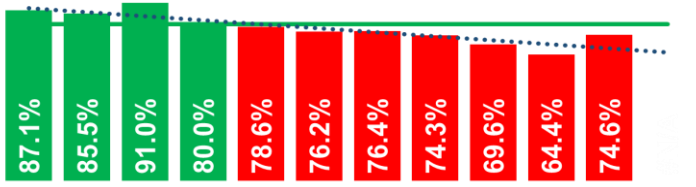
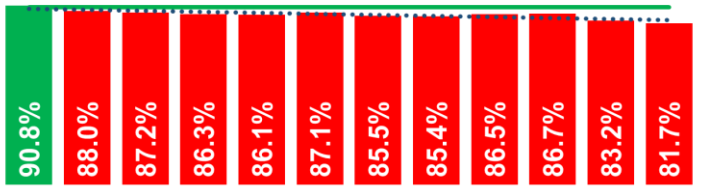
- Over the next 6 months we anticipate maintaining the achievement made over the past year with the improvement in the target. With current resources, due to the continued high demand, it is not likely to improve further in this period.
- The Service Improvement and Development Plan will need to be a 3 - 5year incremental plan to achieve a sustainable service fit for the future needs of our population

What are the risks and mitigations to this (getting back on track)?

- Staff shortages affecting service delivery, in particular the capacity to upload referrals to the external provider and the weekly monitoring required. Increased support and review of admin processes is taking place
- Failure to secure additional funding to enable service improvement and development, including the design of new tenders to meet the changing needs; Work is taking place to ensure we utilise the opportunity's available from the recent WG commitment to invest in ND conditions.
- The need to ensure the development plans include staff to enable change to take place along side core staffing capacity

- 2b: Adults Mental Health Services

Measures: Adults Mental Health Services

Committee	Period	Measure	Target	Actual	Trend
QSE	Jun 22	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital between 09:00 and 21:00 hours that have received a gate-keeping assessment by the CRHT service prior to admission	95%	100%	
QSE	Jun 22	Percentage of service users (adults aged 18 years and over) admitted to a psychiatric hospital who have not received a gate keeping assessment by the CRHTS that have received a follow up assessment by the CRHTS within 24 hours of admission	100%	100%	
QSE	Jul 22	Percentage of mental health assessments undertaken within (up to and including) 28 days from the date of receipt of referral for adults aged 18 years and over	80%	75.2%	
QSE	Jul 22	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for adults aged 18 years and over	80%	81.2%	
QSE	Jun 22	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	74.6%	
QSE	Jul 22	Percentage of health board residents in receipt of secondary mental health services who have a valid care and treatment plan for adults 18 years and over	90%	81.7%	

Narrative 1: Mental Health Measure

Why we are where we are
Improved position for parts 1a and 1b of the Mental Health Measure are the result of the successful delivery plans in the East. Our focus on the reduction of long waiters has delivered results with both Flintshire and Wrexham teams achieving compliance with the 80% target for MHM 1a and 1b at the end of Quarter 1 as projected. The success of the recovery plan is now projected to bring their compliance rate even higher by the end of Quarter 2. West and Centre have had significant issues with staffing combined with a peak in referrals in November that have hindered their recovery. Part 2 of the measure has followed the same challenge and recovery response as for Part 1 with recovery plans in the East enabling them to achieve 94.09% against the 90% target, West achieving 86.23% and Centre at 70.41%.
What we are doing about it
Lessons learned from the East are being shared across all areas. Actions within the recovery plan for East include capacity modelling to optimise staff time, additional sessions, defined minimum assessment slots per day, validation and proactive data management and review of training packages. Additional interim posts have been approved to support recovery in both Centre and West, and recruitment to bring them back to establishment is a key priority within the workforce plan including the work with recruitment agency Just R who are launching a targeted campaign in September to attract active and passive job seekers, utilising various media methods.
When we expect to be back on track
MHM Part 1 remains closely monitored and scrutinised throughout the Division's governance framework and a formal rebasing of projections will be undertaken this month based on the Quarter 1 outturn position. At present the projection is for the Division to be compliant across all areas by end of March 2023. As previously noted both Flintshire and Wrexham are compliant and are projected to remain so.
What are the risks and mitigations to this (getting back on track)?
Some of the success in East has been attributed to the ability to recruit staff before the improvement process and cultural changes took place. At present the depleted staff in West and Centre are the main risk contributing to the position. Mitigating actions are aligned to the recruitment drive and addition of interim posts.

Narrative 2: Adult Psychological Therapy

Why we are where we are

We are pleased to report an upturn in delivery against the secondary care adult specialist psychological therapy waiting times target. We are reporting 74.6% at quarter end regionally, a 10% increase on the previous month's position. Both West and Central areas are compliant with the target of 80% with Central achieving 100% consistently for the past 12 months. The East area showed steady improvement in 2021, but managing long term sickness and two vacancies in key posts in the East has been the main impact on our ability to maintain the target compliance achieved in June to October 2021.

What we are doing about it

Ongoing capacity/demand modelling, validation and proactive data management, and stepped care initiative training and supervision to MDT colleagues are in place to increase access to lower step interventions (Matrics Cymru service delivery model). Staff have been moved from other areas to address backlog, staff on long term sick have been supported to return to work, and we have successfully recruited to posts, although the staff will not be in post until the Autumn. Stepped care access has been increased by multiple modes of delivery, including face to face, group, and on-line groups. These have been standardised and rolled out across the MHLD Division.

When we expect to be back on track

Referrals and waiting times are closely monitored and scrutinised on a weekly basis with action plans in place. The stepped care initiative has been successful in a number of key recruitments this summer and these staff will be in place by October/November 2022. This will support better access across the pathway. The projection is we will secure compliance across all three localities by early 2023.

With a small specialist staffing resource, we continue to manage the significant impact made by maternity leave, sickness, and staff turnover vacancies. We aim to address the impact of this by reducing the established capacity and demand mismatch by plans to secure further SIF funding, for a more sustainable resource long term, better matched to the high demand across the Division.

What are the risks and mitigations to this (getting back on track)?

The risks in a small staff resource remain unpredictable levels of sickness, maternity leave and staff leaving posts. The mitigation in place is active support to staff to ensure retention. We continue with a proactive recruitment drive to attract new recruits with an established All Wales and North of England network to attract potential recruits from the relevant South and North Wales training courses, as well as Liverpool and Manchester and further afield. We are also linked in with HEIW and the Welsh workforce plans and are leading on widening the specialist workforce with innovations, taking two of the first CAAPS cohort in Wales in January 2023. The biggest improvements in the last 3 years have been led by the stepped care initiative, and we have increased that capacity this summer with a range of staff, and this will provide further input including training to MDT colleagues and implementing plans in place.

Narrative 3: Adult Mental Health DToC

Why we are where we are
At the end of Quarter 1, we are reporting 9 delayed patients, well below the average for the past 2 years. The number of bed days lost is reporting at 557, a significant reduction from the 1125 reported at the end of Quarter 4 2021/22. Availability of appropriate placements for our complex patients, particularly those with combined mental and physical health needs, remains a limiting factor and this has been further impacted by Covid-19 restrictions. Due to the complexities of some of our patients, step down care would not be possible due to the bespoke nature of the placements needed to safely care for our patients.
What we are doing about it
Daily discussions take place for all delayed patients to discuss progression of discharge from acute setting. Where possible and appropriate, discharge arrangements are discussed with patients and families / carers on admission, and for those patients needing placements on discharge the discussions are ongoing and collaborative throughout the patient's inpatient stay.
When we expect to be back on track
Flow into and out of inpatient services remains a key priority for our Division and although we are pleased with the reduction reported at the end of Quarter 1, we remain proactive as we know that factors outside of our inpatient facilities that would enable a timely discharge make our position fragile. MDT discussions continue to take place and issues escalated through local governance processes.
What are the risks and mitigations to this (getting back on track)?
Availability of appropriate placements for our complex patients remains the biggest factor with 6 of our 9 delayed patients waiting for placements. All of these delayed patients have definitive needs within their placement and the arrangements are being managed and monitored daily along with continued review of the patients to accommodate any change in discharge requirements.

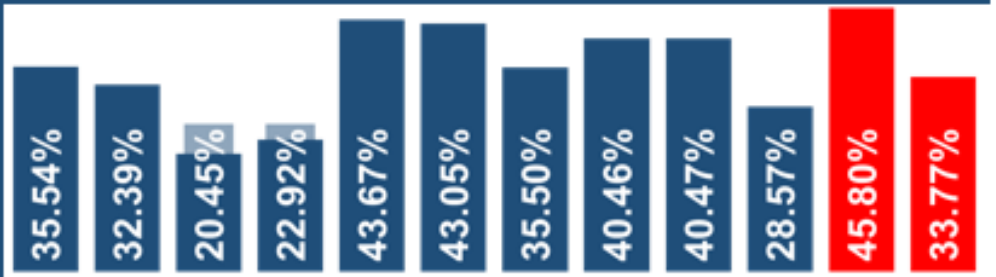
- 2c: Hospital Infection Control

Measures: Hospital Infection Control (bacteraemia cases)

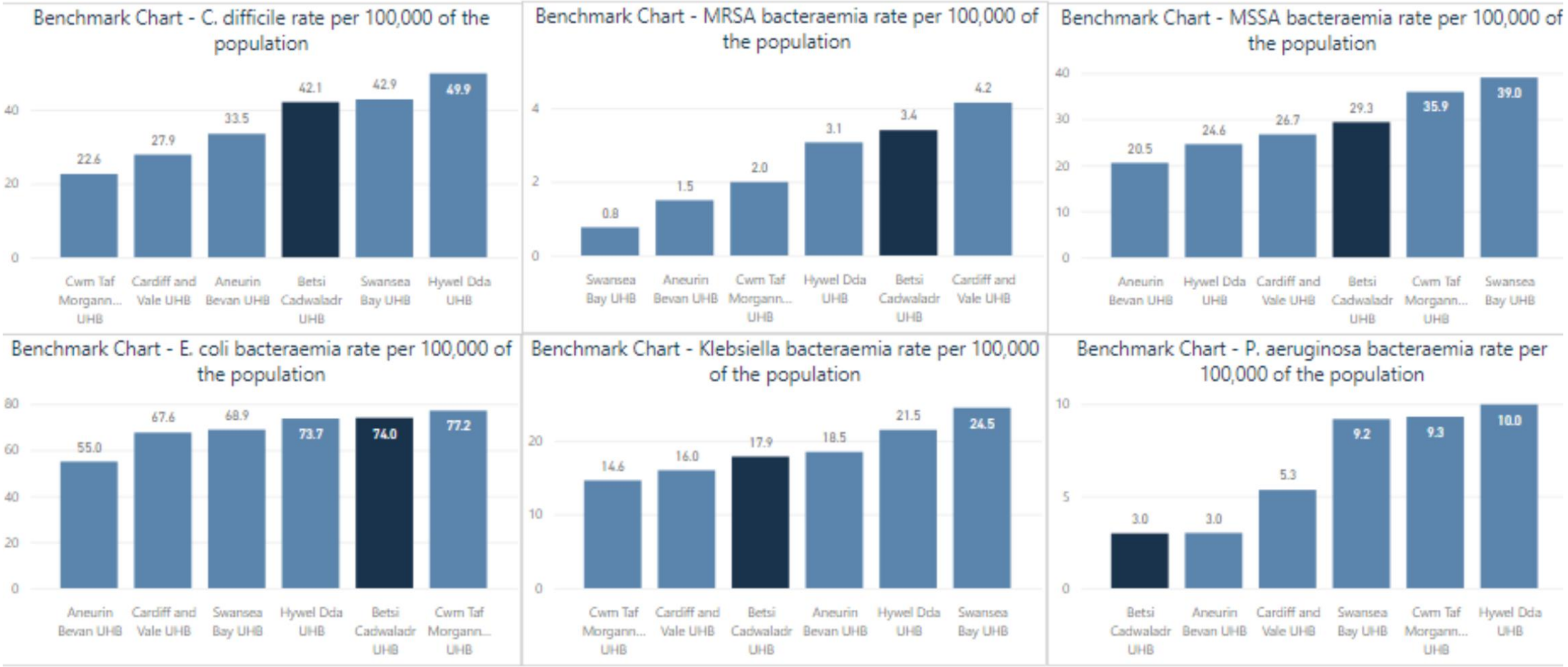
Committee	Period	Measure	Target	Actual	Trend (A S O N D J F M A M J J)
QSE	Jul 22	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp	TBC	42	53 73 86 95 108 119 127 138 8 19 29 42
QSE	Jul 22	Cumulative number of laboratory confirmed bacteraemia cases: ; Aeruginosa	TBC	7	17 22 24 30 31 33 36 37 1 7 7 7
QSE	Jul 22	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E-coli	TBC	74.44	69.87 66.36 64.99 63.80 64.35 62.58 63.69 62.13 * 68.06 66.72 74.44
QSE	Jul 22	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: S.aureus bacteraemias (MRSA and MSSA)	TBC	33.17	26.78 25.81 26.43 27.01 26.98 27.98 27.03 25.88 * 31.48 35.93 33.17
QSE	Jul 22	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: C.difficile	TBC	42.96	31.88 35.45 37.34 37.22 34.91 32.22 31.85 30.99 * 36.58 36.50 42.96

*Clarifying data

Measures: Hospital Infection Control (Covid-19 cases)

Committee	Period	Measure	Target	Actual	Trend
QSE	Jul 22	Percentage of confirmed COVID-19 cases within hospital which had a **definite** hospital onset of COVID-19	Reduction vs. same month 2021-22	33.77%	
QSE	Jul 22	Percentage of confirmed COVID-19 cases within hospital which had a **probable** hospital onset of COVID-19	Reduction vs. same month 2021-22	16.88%	

Comparison Charts to all Health Boards in Wales – Apr 2022 to July 2022



Rolling period refers to Cumulative April 2022 to Date (July 2022)

Narrative 1: Infection Prevention – Bacteraemias

Why we are where we are
C.diffiicile infection rates for Wales as a whole remain above trajectory. Several of the C.difficile infections this year appear to be relapses. 5 of the first 7 MRSA bacteraemias were community acquired; the other 2 were from the same patient. MSSA bacteraemias have been reviewed by the microbiologists and no commonalities identified. For gram negative bacteraemia (E.coli, Pseudomonas and Klebsiella) rates are fairly static but initiatives aimed at reducing numbers continue including promoting the urinary catheter passport and launch of a new protocol to ensure little used taps are flushed regularly.
What we are doing about it
• Detailed Patient Incident Reviews are being completed for each infection and reviewed by a multi-disciplinary team to identify lessons learnt. • MRSA: micro-teaching sessions are being delivered and cascaded on the wards and the PIR process in primary care is being reviewed. • C.difficile: A Task and Finish group has been organised to review all C.difficile pathways and treatments. An in depth case review is being carried out in cancer patients led by a Research scientist. Acute sites are being asked to establish a programme of bay to bay high level disinfection. • Pseudomonas: A mapping exercise is being carried out to see if there is any correlation between infections and fails in water sample testing.
When we expect to be back on track
Data is refreshed and reviewed at the Infection Prevention Sub Group on a monthly basis showing comparison to trajectory. BCU expect to achieve target rates by March 2023. Common issues identified from PIRs are being used as the focus for the Safe Clean Care - Harm Free Campaigns this year; Quarter 1 initiatives are in progress and Q2 being planned, these include a focus on bed space cleaning and appropriate use of PPE.
What are the risks and mitigations to this (getting back on track)?
• Resource within the Infection Prevention team - formal risk assessments in place with action plans and work being prioritised. • Challenges with domestic capacity and cleaning and achieving the room disinfection programmes with limited space to decant patients to – Hydrochlorous acid can be used which is faster and safer than Hydrogen Peroxide Vapour. • Poor compliance with antimicrobial stewardship – Antimicrobial Stewardship programme and Action Plan in place. • Clinical staff engagement required to make changes to practice; greater input and support being requested from the medical teams.

Narrative 2: COVID-19

Why we are where we are
• Numbers of patients affected and numbers of outbreaks appear to have stabilised. Associated staff sickness also reduced. • Introduced LFD testing on Day 5 & 6 for Covid positive patients who show signs of improvement of respiratory symptoms and absence of fever. Staff who experience symptoms to use LFTs in place of PCR tests. • Staff that are a household contacts of a positive case to receive a Covid test using ID Now (PCR if ID Now not available) to enable staff to return to work earlier.
What we are doing about it
• Asymptomatic unscheduled patients requiring admission are to be tested via LFT. • PHW leading research to understand at ward level, what might predict a Covid outbreak e.g. staffing rates, ward turnover, community transmission rates and ventilation. • Respiratory impact data being collected in the West – need to identify resource to continue this and complete it for other sites. • Amending the guidance re appropriate use of PPE required for CPR in line with latest national guidance.
When we expect to be back on track
The situation and trends in data continues to be monitored on a weekly basis. Covid Huddles held regularly led by Emergency Preparedness Resilience and Response Lead.
What are the risks and mitigations to this (getting back on track)?
Staff must be up to date with the latest changes in policies and protocols and remain vigilant – Comms are sent out globally when changes are made and policies and protocols on the intranet site are kept up to date. Pressure on patient flow preventing appropriate patient movement – Infection prevention work closely with site managers to prioritise side room usage and support patient flow decisions.

Chapter 3

Quadruple Aim 3:

The health and social care workforce in Wales is motivated and sustainable

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

- 3a: Staff Resources
- 3b: Staff Engagement

Measures: Staff Resources

Committee	Period	Measure	Target	Actual	Trend
QSE		Percentage of staff who have recorded their Welsh language on ESR who have Welsh language listening/speaking skills levels 2 (foundational level) and above	Improve Bi-Annually		**New Measure - Awaiting Data**

Measures: Staff Engagement

Committee	Period	Measure	Target	Actual	Trend
QSE	2020/21	Overall staff engagement score	Improve Annually	**73%**	
QSE	2020/21	Percentage of staff who report that their line manager takes a positive interest in their health and well-being	Improve Annually	**62.80%**	

Chapter 4

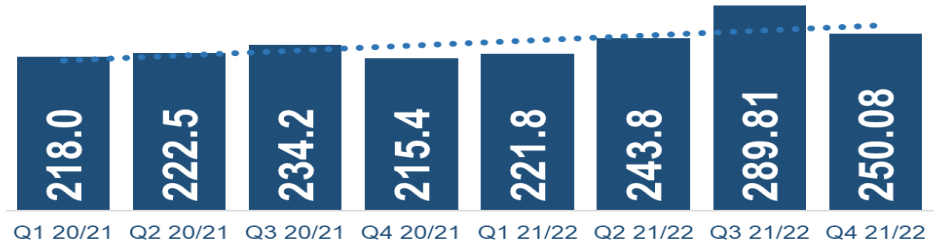
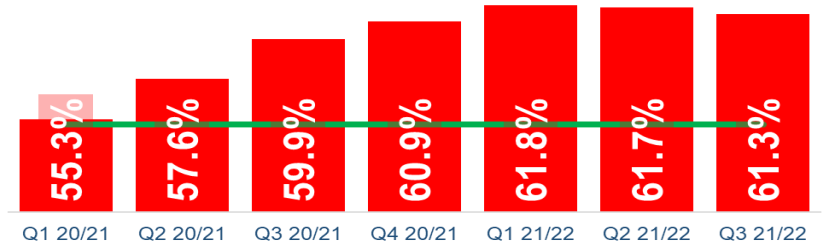
Quadruple Aim 4:

Wales has a higher value health and social care system that has demonstrated rapid improvement and innovation, enabled by data and focused on outcomes

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

- 4a: Clinically Effective Prescribing

Measures: Clinically Effective Prescribing

Committee	Period	Measure	Target	Actual	Trend
QSE	Q4 21/22	Total antibacterial items per 1,000 specific therapeutic group age-sex related prescribing units (STAR-PUs)	Improve Quarterly	250.1	
QSE	Q3 21/22	Percentage of secondary care antibiotic usage within the WHO Access category	55%	61.3%	
QSE	Q4 21/22	Number of patients aged 65 years or over prescribed an antipsychotic	Qtr on Qtr Reduction	2420	
QSE	Q4 21/22	Opioid average daily quantities per 1,000 patients	4 Qtr Reduction	4644.9	

Chapter 5*

Operational and Local Measures

Operational Measures *(ref: A-H), which are not routinely reported at National Levels, but must be tracked*

Local Measures *(LM---) that do not form part of the NHS PF 2022-23, but which have been identified by the Health Board as important to monitor, and escalate if needed*

**This chapter is being reviewed as previously nationally reported measures have been retired with new Operational and Local Measures to be confirmed and collected accurately*

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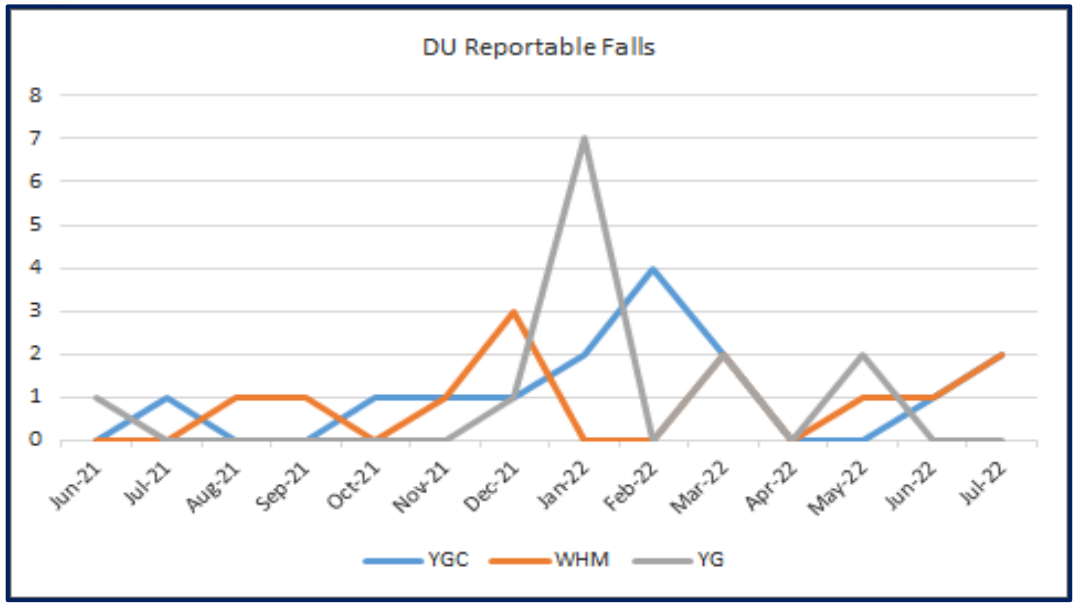
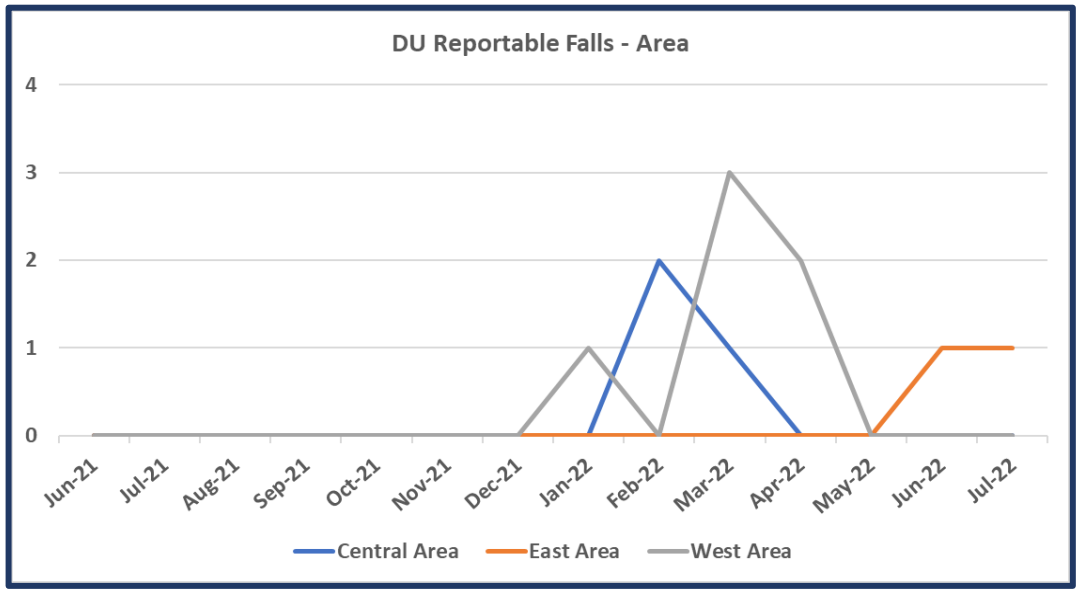
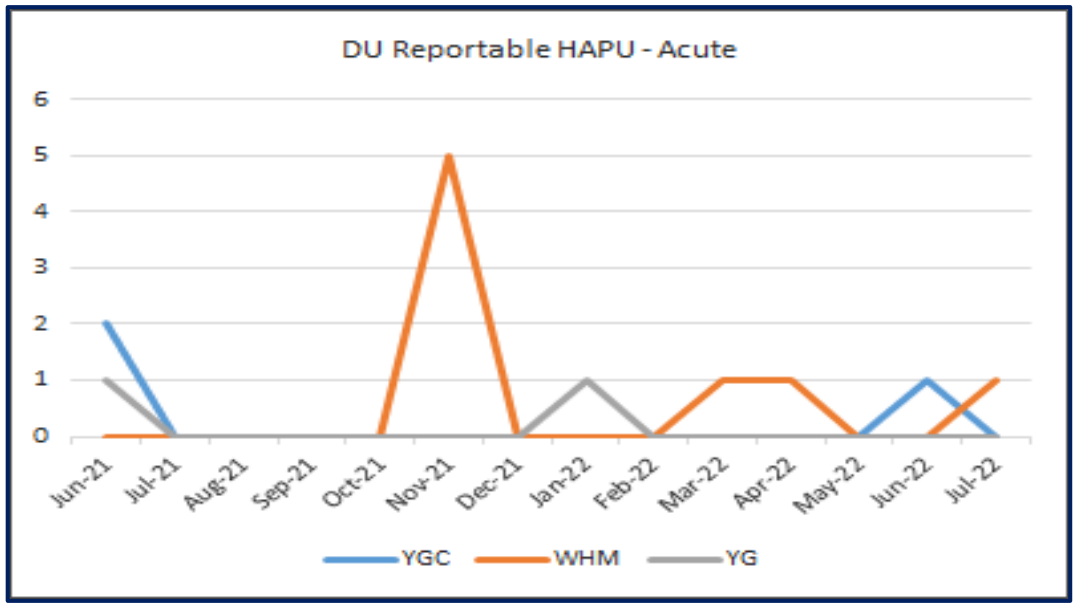
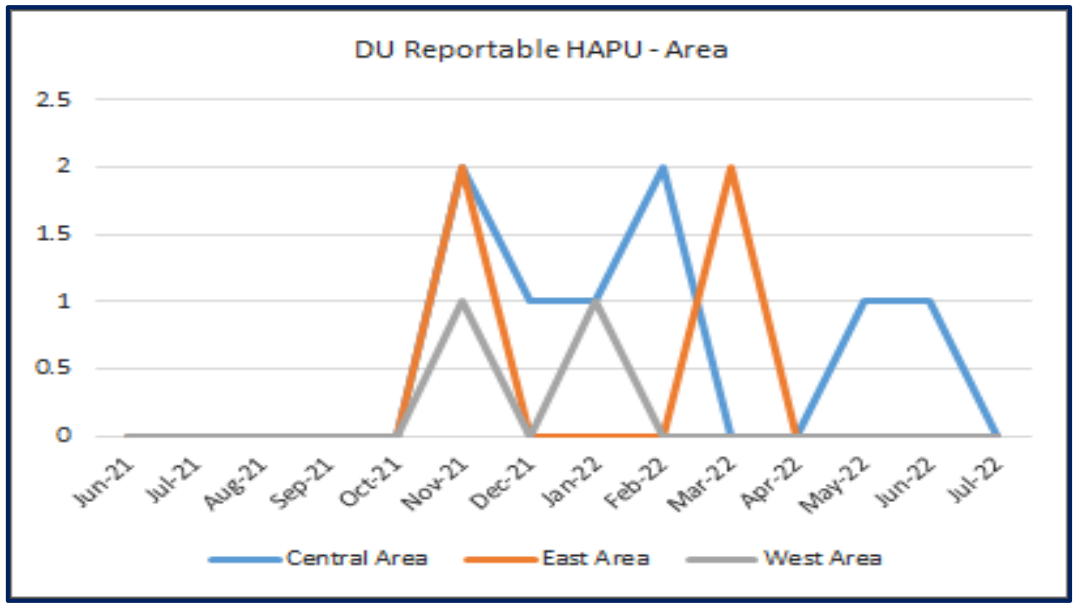
- 5a: Incidents and Complaints

Charts 1: Incidents

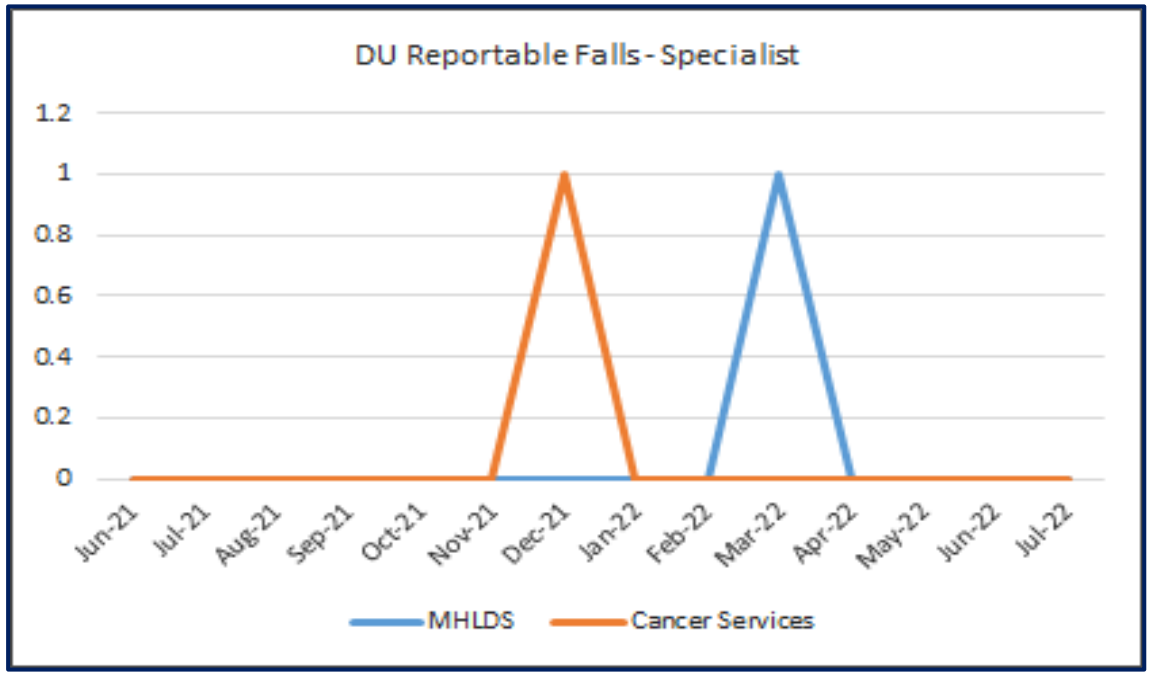


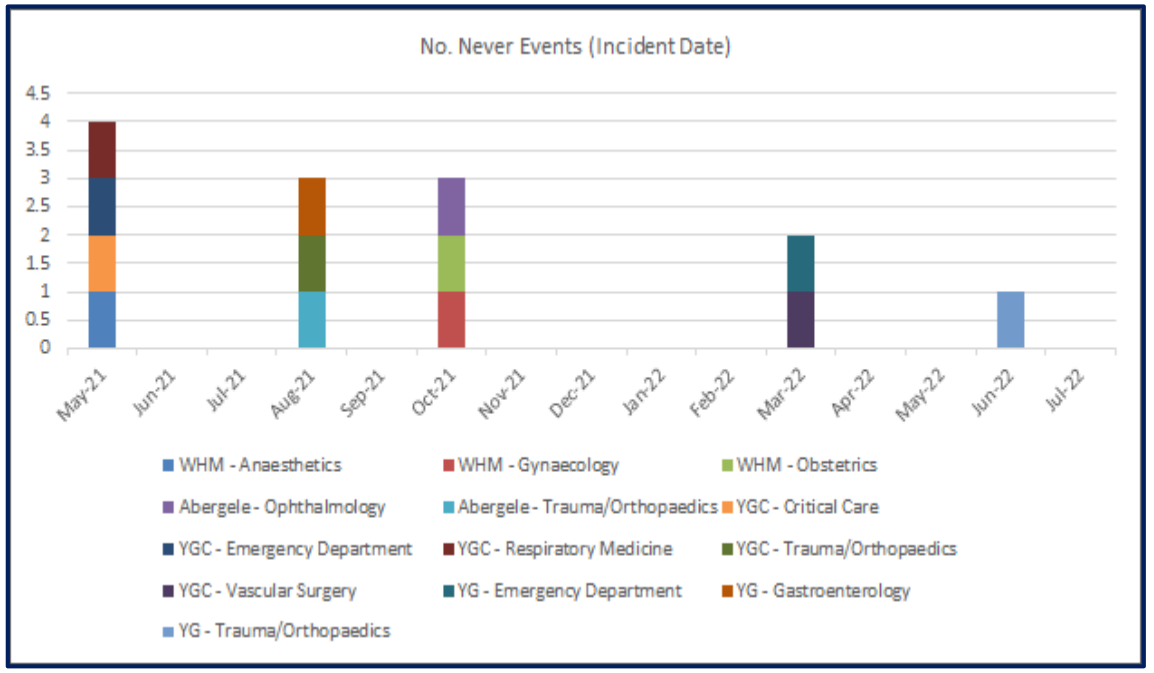






Charts 2: Incidents





Narrative 1: Incidents

Why we are where we are

One never event was reported in this time period. This related to a wrong implant prosthesis. A size 5 femoral component was inserted with a size 4 tibial tray and size 4 polyethylene insert. The surgical team and the company representative did not recognise that this was an incorrect combination, and that a size 4+ polyethylene insert should have been used as recommended by the manufacturers and operative technique available in theatre.

The number of falls and healthcare acquired pressure ulcers is detailed in the Patient Safety Report.

One safety alert (PSN057 – Steroid Card) remains overdue.

What we are doing about it

An investigation has commenced into the Never Event. A Rapid Review and Rapid Learning Panel was held to identify immediate learning. Detail on this incident is included in the Patient Safety Report.

The work to address falls and healthcare acquired pressure ulcers is detailed in the Patient Safety Report. In respect of the safety alert, a new clinical policy is progressing through the approval process.

When we expect to be back on track

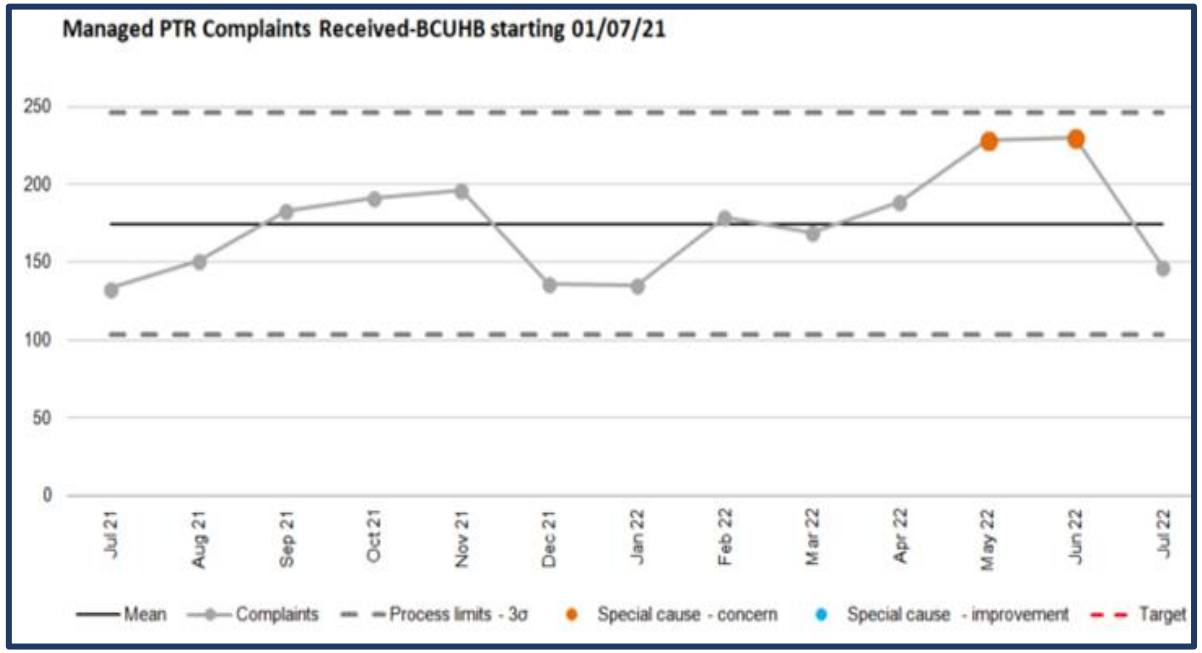
The investigation into the Never Event is underway. At this point, this is one Never Event in the financial year which is a notable reduction to previous years.

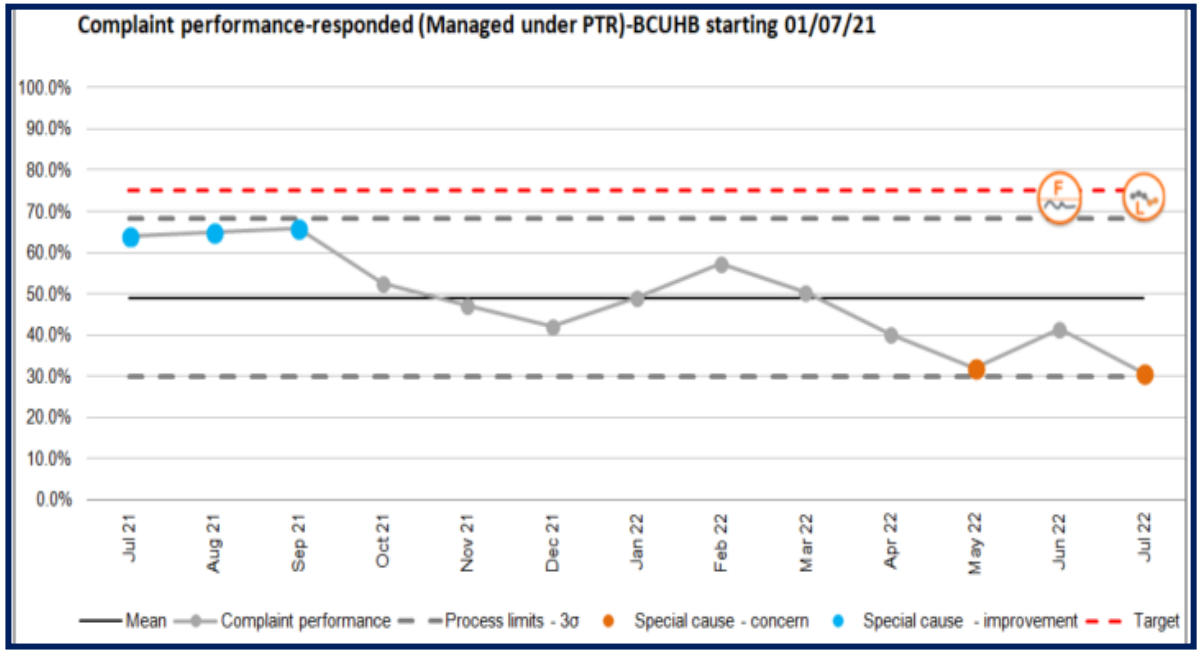
The work to address falls and healthcare acquired pressure ulcers is detailed in the Patient Safety Report. In respect of the safety alert, the aim is to have the new clinical policy approved by the end of September 2022.

What are the risks and mitigations to this (getting back on track)?

There is a risk that the policy approval process may delay the new clinical policy being approved by the deadline above. This is being actively monitored by the Quality Team and the Executive Medical Director has been sighted on the issue.

Charts: Complaints





Narrative 2: Complaints

Why we are where we are

During the month of July 2022, 30.64% of complaints were responded to within 30 working (against a target of 75%) with 441 overdue complaints. The response rate has been severely impacted due to the increasing number of complaints received across the Health Board and the impact of staffing and operational pressures. The impact of the Covid pandemic has increased the number of delayed appointments and waiting times, which has contributed to delayed treatment, and an increase in complaints in light of these factors.

What we are doing about it

A weekly complaints report is cascaded across all services with proactive support by the Complaints Team, and by PALS in the resolution of Grade 1 and 2 Complaints. Scrutiny is consistently being applied, ensuring that all complaints are managed under Putting Things Right as required, whilst seizing opportunities to provide timely resolution where applicable. This has already demonstrated a gradual reduction in the number of complaints managed under Putting Things Right where there is no allegation of harm. Specific review and support meetings have commenced with the Directors and Heads of Nursing, providing an overview of the current status of their complaints, highlighting the number of complaints overdue and grading in order to implement a collaborative approach on complaint management. A Complaints Recovery Plan is in development and delivery in order to address the backlog; this includes a pro-active approach in filtering the complaints as they are received via effective triaging and support from the PALS teams in addition to a plan for complaints management “rapid resolution workshops” across sites to resolve the backlog of overdue complaints.

When we expect to be back on track

The aim is for recovery of the position by the end of the financial year, with a focus on prioritising the most significant and most overdue first.

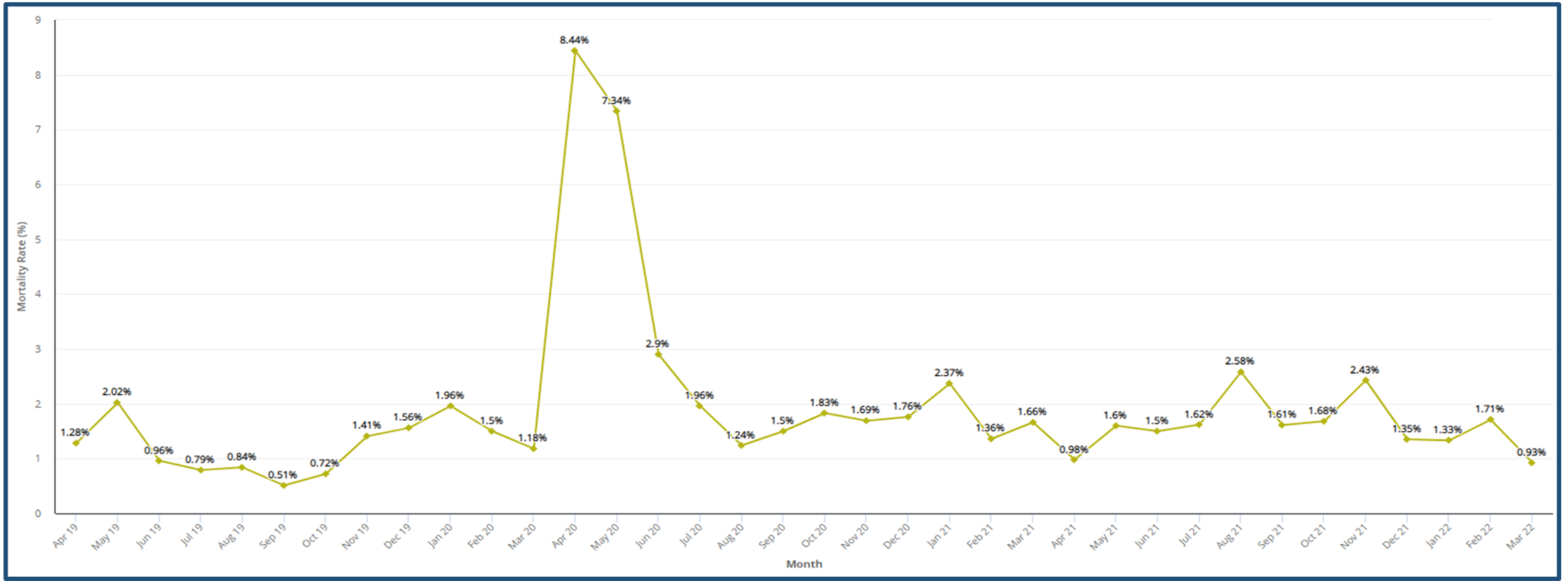
Progress will be monitored via the weekly reporting mentioned above but also through Accountability Meetings with the Executive Team.

What are the risks and mitigations to this (getting back on track)?

The capacity within services to manage both the current and backlog position is the main risk. Additionally, a risk exists that services may not achieve trajectories in the Complaints Recovery Plan impacted by the current re-organisation, particularly vacant posts, and the impact of potential staff absence during what is likely to be a busy winter period. In mitigation, dynamic management of the recovery plan is in place through weekly review and monitoring in Accountability Meetings with the Executive Team.

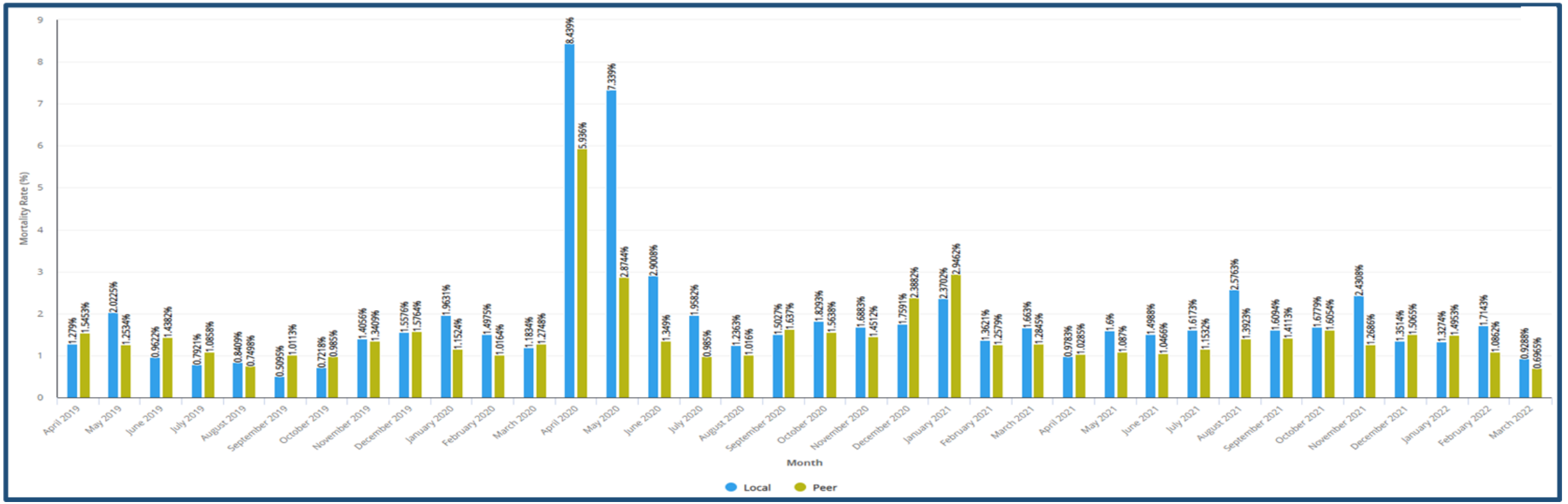
• 5b: Mortality and Sepsis

Chart 1 Mortality: Trend Apr 2021 – Mar 2022



The time series chart above shows data from April 2019 to March 2022. There was a large spike in mortality rate from April to June 2020. This was right at the start of the Covid-19 pandemic so this could be due to patients having contracted Covid-19, as these patients aren't excluded from the mortality rate indicator. More recently, looking at the last 12 months, there have also been peaks during August 2021 and November 2021.

Chart 2 Mortality: Rate Vs Other Welsh Health Boards



The bar chart above shows the monthly mortality rate for BCUHB (blue) compared with the monthly mortality rate for the other Welsh health boards (green). It can be seen from this chart that the other HB's did not experience such large spikes in mortality rate in the gastroenterology treatment function between April and June 2020 as was apparent in BCUHB. In addition, the peaks seen in BCUHB during August and November 2021 were not seen in the other health boards.

Narrative 1: Mortality

Why we are where we are

Since October 2021, the All Wales Medical Examiner Service (MES) has been reviewing deaths independently from BCUHB. Recent data from the MES, demonstrates a sharp rise in cases reviewed and returned to the Health Board (HB). BCUHB is the only HB in Wales where 100% of deaths from acute sites are reviewed, latest figures reveal 250 deaths per month. The decision to further review any cases with learning identified and actions resulting from the review is the responsibility of the HB. The MES has recently written to the HB to inform that they are also going to look at community deaths and deaths in primary care, this is likely to be a statutory obligation by April 2023.

What we are doing about it

Appointed an Associate Medical Director and a Mortality Facilitator. The operational role is to receive the ME referrals into a dedicated inbox, and 'sieve and sort' them in an appropriate time frame. The options are then to potentially close the case if no opportunity for learning is perceived, or direct to the established governance arrangements, such as the Patient Advice and Liaison Service (PALS), Putting Things Right, (PTR) Covid Inquiry, so not to duplicate current structures or start parallel investigations. Those where there is an opportunity for significant learning are sent to the established mortality hubs. Each site will review the case at a Mortality and Morbidity meeting to capture the learning. Each hub is encouraged to present the case and learning at the ' Learning from Mortality Panel' (LFMP), a multi-professional forum. Work is ongoing to capture 'quick wins' , and ensure the cases discussed and outcomes of discussions lead to change in practice to improve the quality of care.

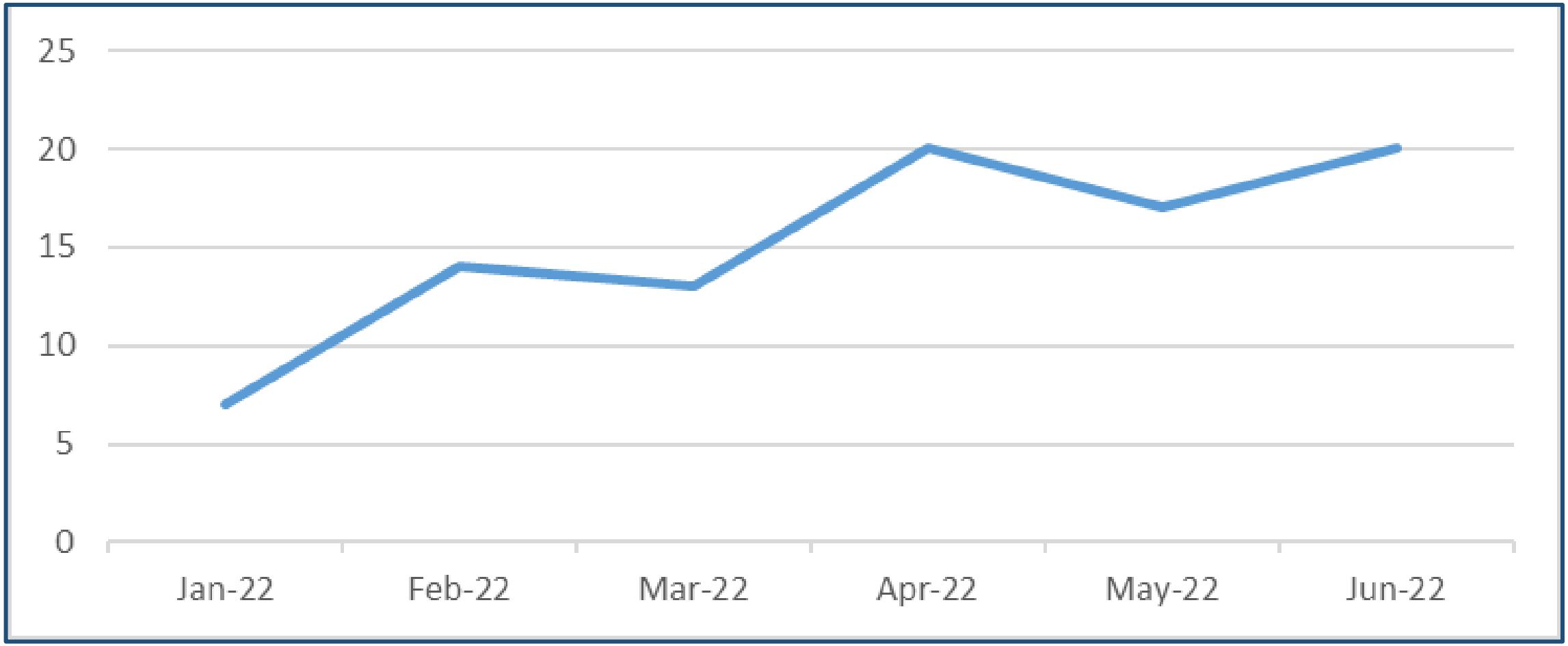
When we expect to be back on track

In terms of 'back on track' the above has brought about a much more cohesive approach to mortality reviews, and since Jan 2022, we have significantly reduced the risk around the backlog of the ME inbox. Reviews are disseminated to all sites and areas across BCUHB, and when learning has been identified these are presented to the All BCUHB Learning from Mortality panel. The aims of the panel is to identify learning and act on it in a pan BCUHB sense. Where themes are identified, a co-ordinated response is designed, with the aim of flagging through existing governance structures such as CEG. The mortality team continues to develop at a corporate level, and also with the 'hubs' and the aim to develop a robust mortality network through BCUHB. The BCUHB Mortality team is active in both the All Wales Steering Group and Work stream, developing a National model to learn from mortality. The governance structures and processes developed in BCUHB have been mirrored and taken on in other HB's including Velindre and Hywel Dda. The processes and practices around mortality will continue to develop in 2022, with the aim of a 'learning from mortality conference' taking place in North Wales in late 2023.

What are the risks and mitigations to this (getting back on track)?

Keeping momentum and focus on mortality in the sites and areas is key. There are many other competing issues for leaders and important to keep on the agenda.

Chart Sepsis: No. of Sepsis, cause of death Jan-Jun 2022



Narrative 2: Sepsis

Why we are where we are

Sepsis continues to regularly contribute to mortality in BCUHB. Of the approximate 700 cases referred back from the Medical Examiner Service (MES) to the HB , 91 included sepsis either as a direct cause or a contributor to mortality. On a month by month basis sepsis has increased as a contributor to mortality from 5% in January to 20% in June (see figure on previous page. Deaths from Sepsis was identified from the following sites proportions: 36% were from West, 21% from East and 43% from Central acute site. The cause and key drivers are myriad. Many of the cases are in an increasing frail population, who spend longer in hospital- which increasing allows the opportunity for nosocomial infections from Covid, to hospital acquired pneumonias to clostridium difficile infections. Issues around 'flow' and discharge mean patients often have delayed discharge, longer trolley waits and delays in being seen. Mobilisation and physiotherapy- evidence based to reduce HAPS is reduced because of pressure on staffing levels in both nurses and allied health professionals. Antimicrobial stewardship and training around sepsis 6 bundles and correct use of the micro guide also contribute to reducing mortality from sepsis.

What we are doing about it

From a mortality perspective sepsis needs to be identified as a 'theme' and tracked through CEG to look at multiple strands of improvement work. Any actions need to be formally actioned and tracked through the Learning from Mortality Panel (LFMP).

When we expect to be back on track

To improve performance- requires a multi-level approach. The LFMP can support and track issues around specific cases- and also track the themes. The LFMP is an ALL BCUHB meeting, so can cascade and pick up issues across BCUHB including the community, site, nursing homes, cancer and WAST. Issues can be escalated through CEG

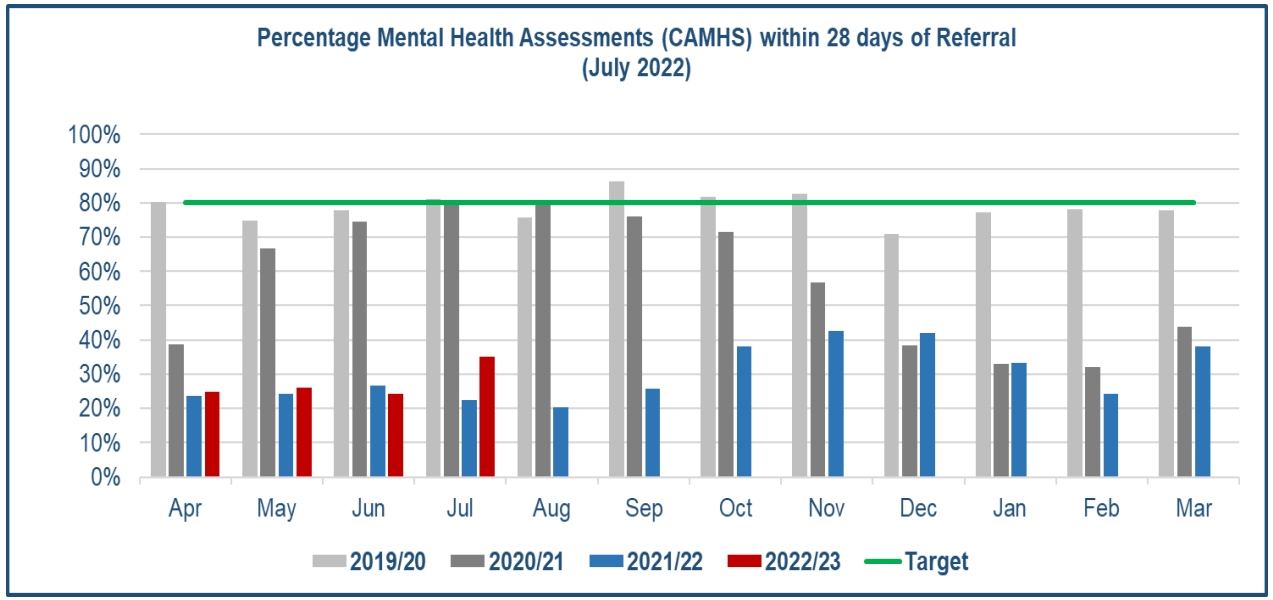
What are the risks and mitigations to this (getting back on track)?

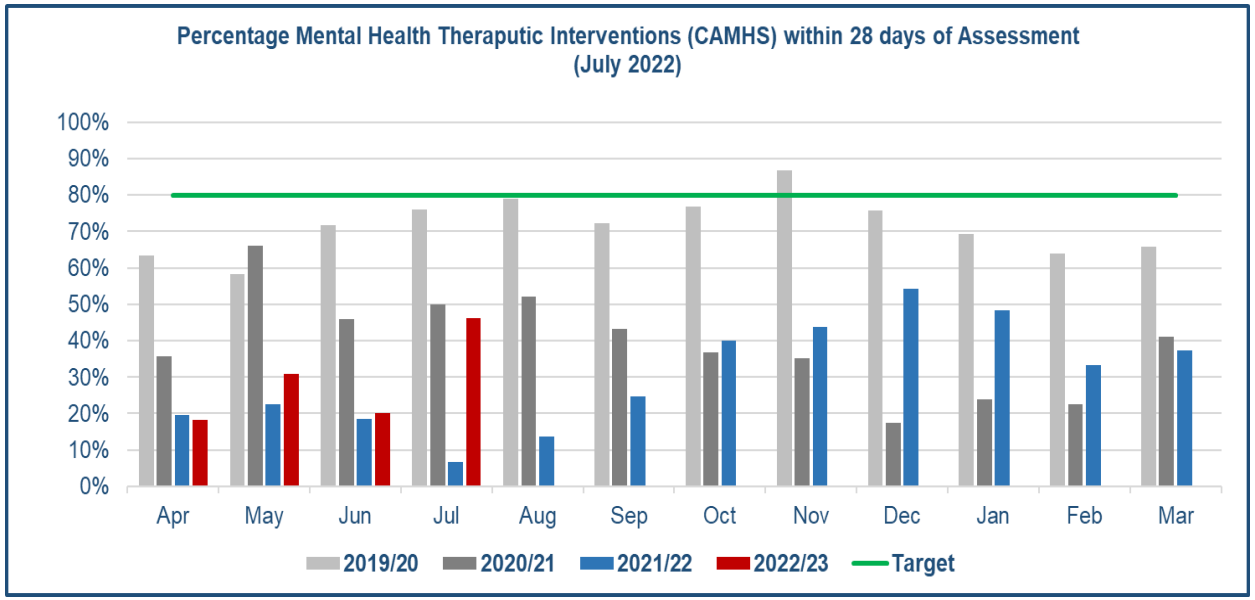
Risk around timeline are engagement in the LFMP- and developing a network across BCUHB that can learn, discuss and act on issues around sepsis and escalate appropriately.

Mitigation is to continue to develop and encourage the formal structures around mortality reviewing in the HB with the aim of a multi-professional holistic approach to understanding how sepsis contributes to mortality- and where it is preventable and distribute the learning where it occurs.

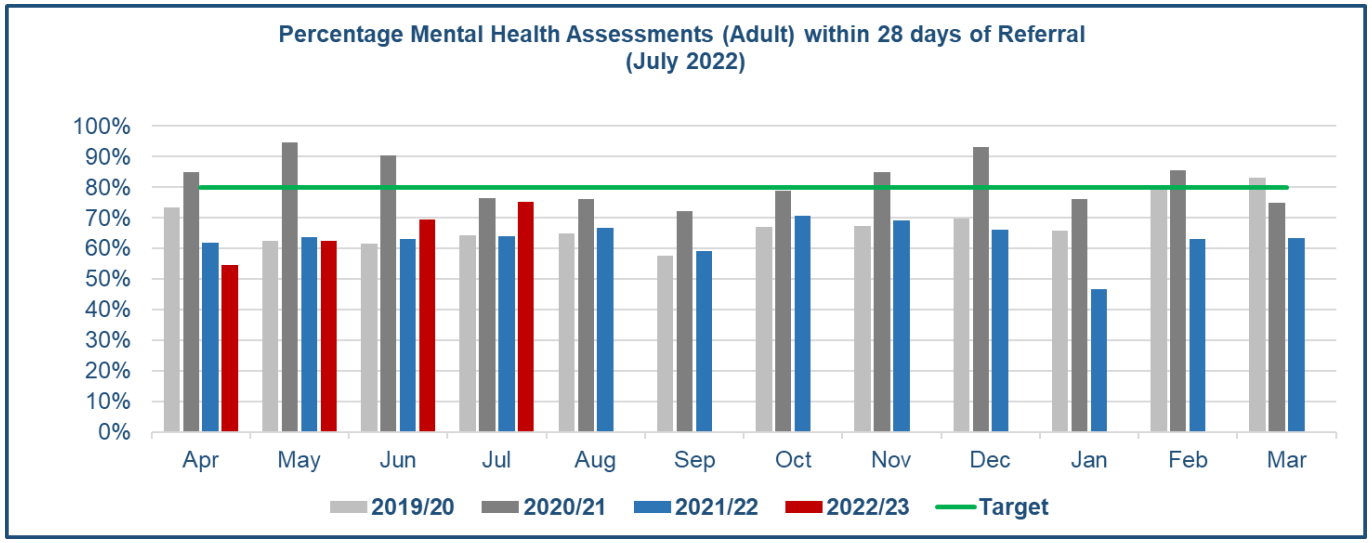
- Additional Information

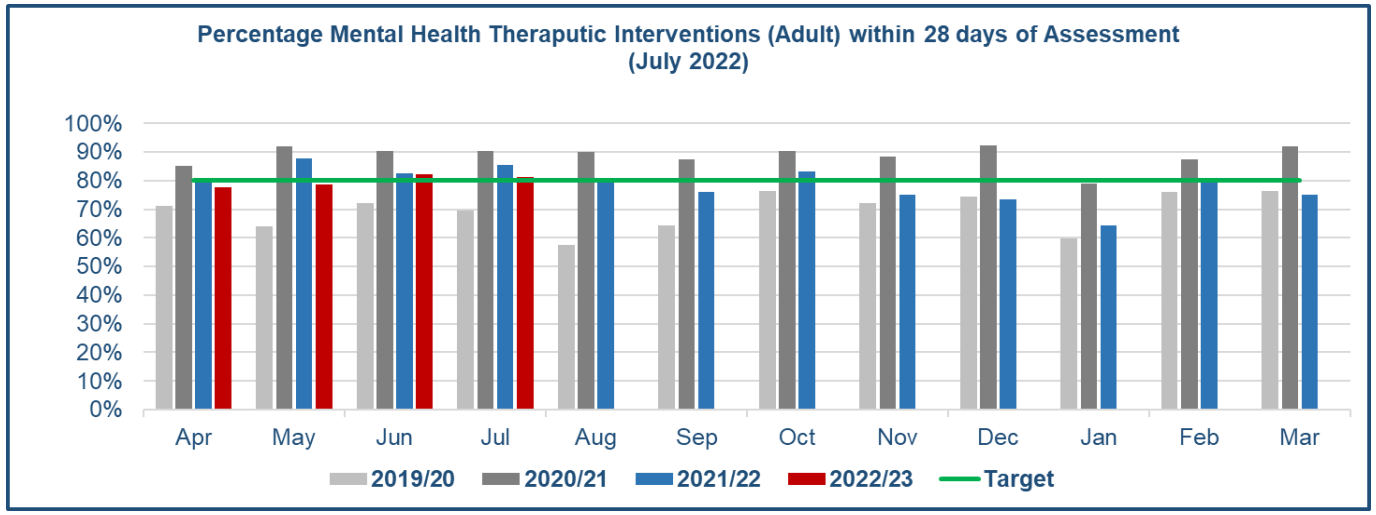
Charts: CAMHS

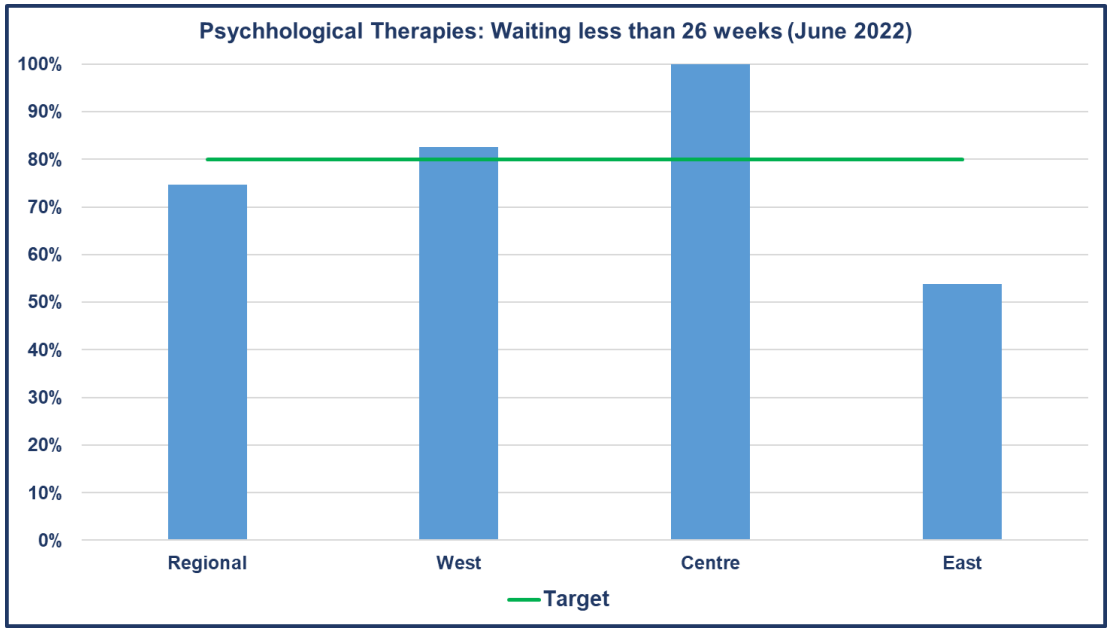




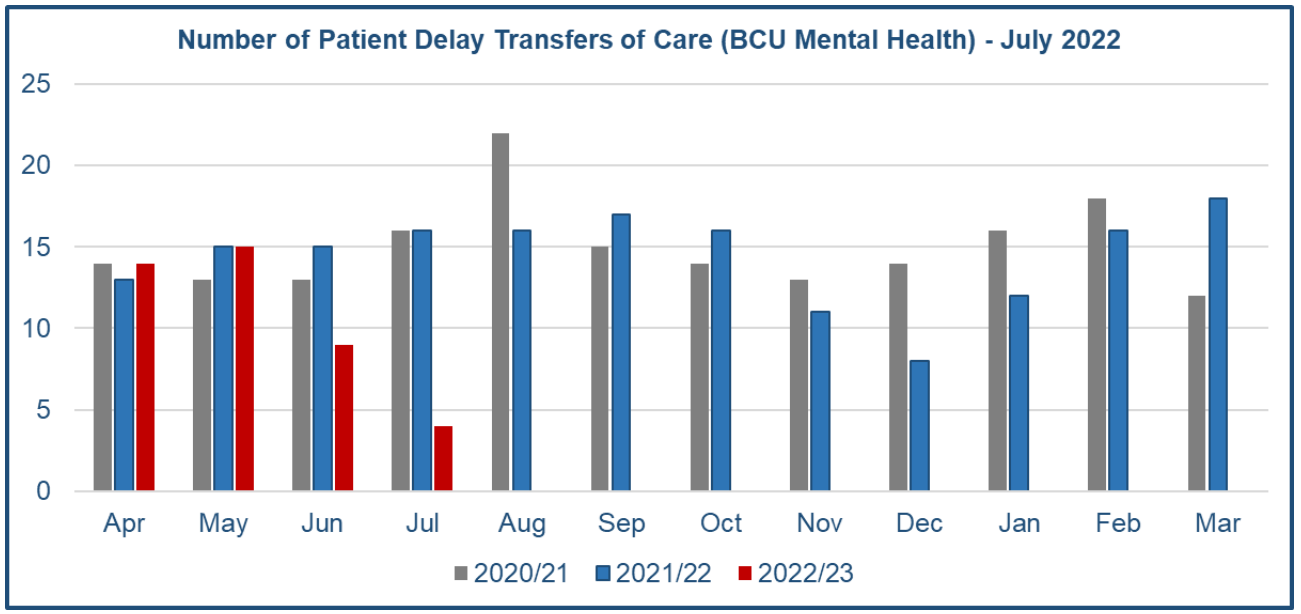
Charts: Adult Mental Health

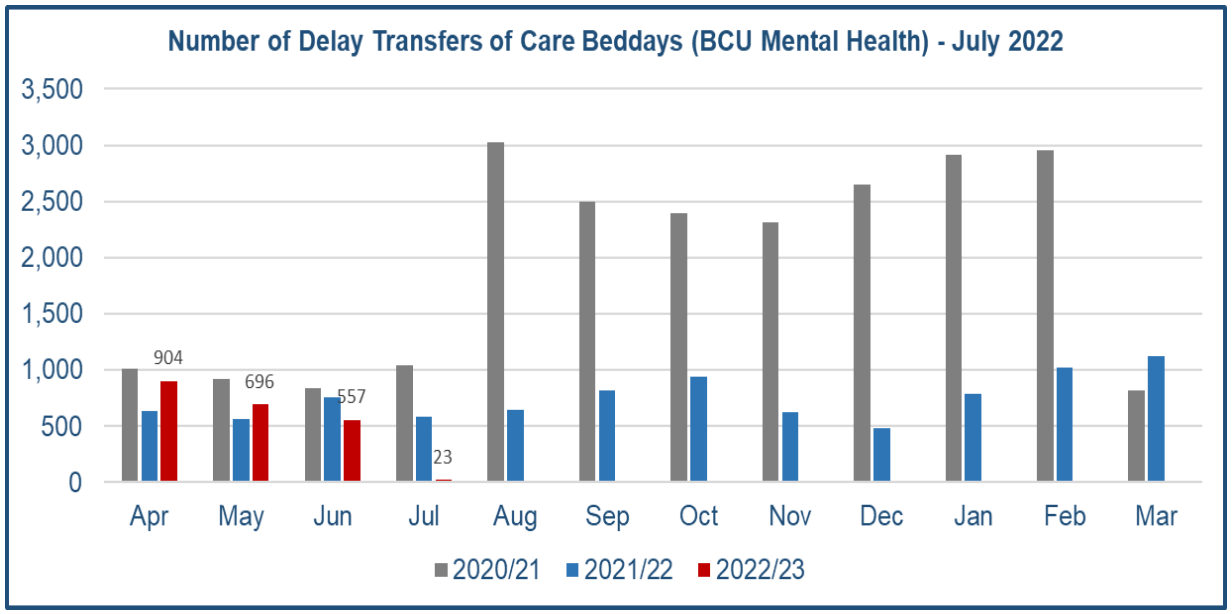




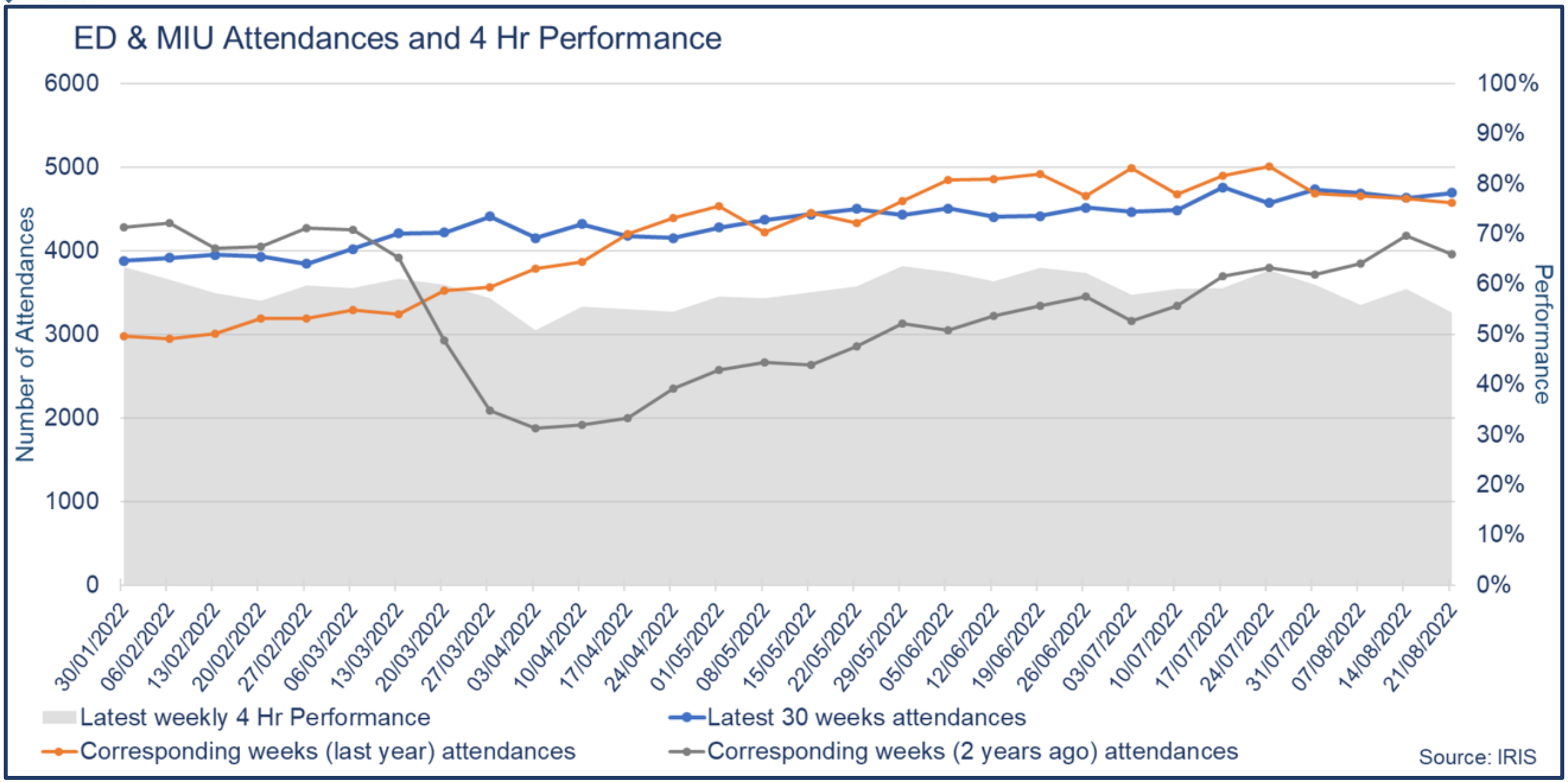


Charts: MH Delayed Transfers of Care





Impact of COVID-19 Pandemic on Unscheduled Care



Impact of COVID-19 Pandemic on Unscheduled Care

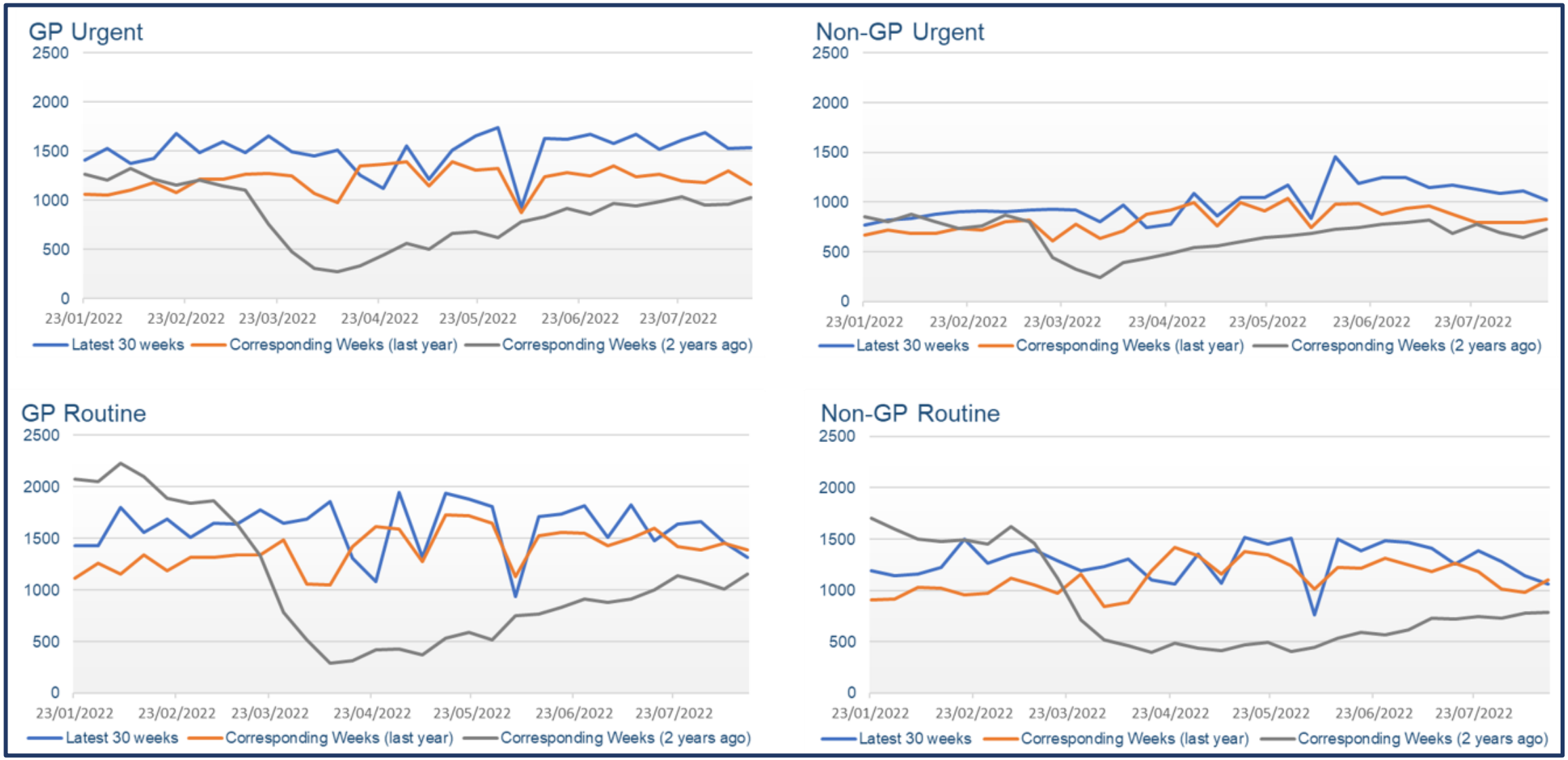
Unscheduled Care Performance by Site
15th August - 21st August 2022

Measure	West	Centre	East	BCU
ED&MIU Number of Attendances	1645	1787	1266	4698
ED&MIU 4 Hour Performance	57.87%	61.89%	39.18%	54.36%
ED Number of Attendances	1098	1118	1080	3296
ED 4 Hour Performance	39.53%	39.53%	31.57%	36.92%
ED 12 Hour Breaches	280	290	306	876
1 Hour Ambulance Handover Breaches	150	157	116	423
Red 8 Minute Ambulances	59	65	55	179
Red 8 Minute Performance	40.68%	49.23%	45.45%	45.25%

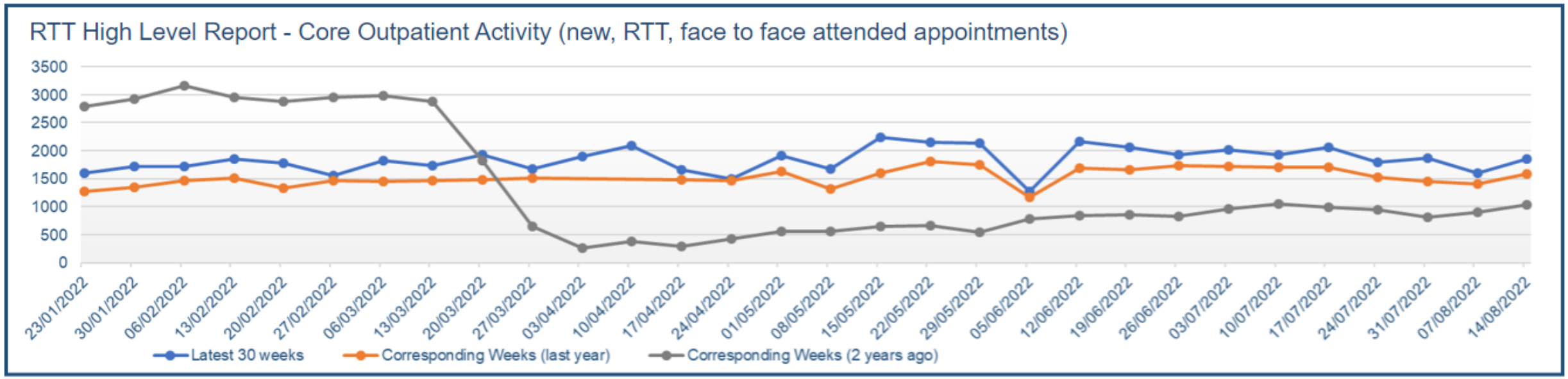
Red 8 Minute Ambulance data is unvalidated and not for sharing outside this report

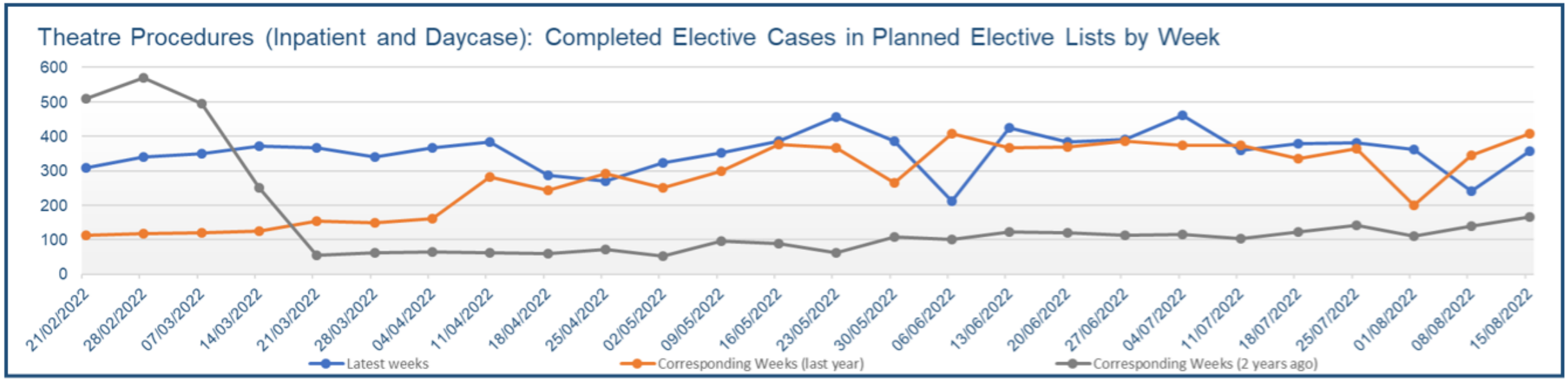
Sources: Red 8 Minute - WAST Health Board Area Report; ED and Handover - IRIS, accessed 22/08/2022

Impact of COVID-19 Pandemic on Referral Rates



Impact of COVID-19 Pandemic on Planned Activity





- Further Information

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

Quality & Performance Report
Betsi Cadwaladr University Quality, Safety and Experience Committee

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

- tolerances for red, amber and green

Further information on our performance can be found online at:

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

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

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

Report title:	Patient Safety Report June 2022 – July 2022		
Report to:	QSE Committee		
Date of Meeting:	Tuesday, 06 September 2022	Agenda Item number:	
Executive Summary:	This report provides the Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway.		
Recommendations:	The committee is asked to receive this report.		
Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery		
Report Author:	Matthew Joyes, Associate Director of Quality Dr Kath Clarke, Head of Patient Safety Sarah Musgrave, Patient Safety Lead Manager		
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒

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

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

There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.

Link to Strategic Objective(s):	Quality
Regulatory and legal implications	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	BAF21-10 - Listening and Learning
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	N/A
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	BAF21-10 - Listening and Learning
Reason for submission of report to confidential board (where relevant)	N/A

Next Steps: N/A

List of Appendices: Patient Safety Report (this report now includes HIW regulatory activity)

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

Patient Safety Report to the QSE Committee June-July 2022

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

Patient Safety Report
June 2022 - July 2022

INTRODUCTION

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

The Patient Safety Team, part of the Quality Directorate, is responsible for facilitating and overseeing the incident process, the safety alert process, the collection of patient safety data and reporting, and patient safety culture, learning and improvement (working with clinical leaders and specialists such as the Transformation and Improvement Directorate). The Healthcare Law Team, also part of the Quality Directorate, facilitate and manage claims and inquests.

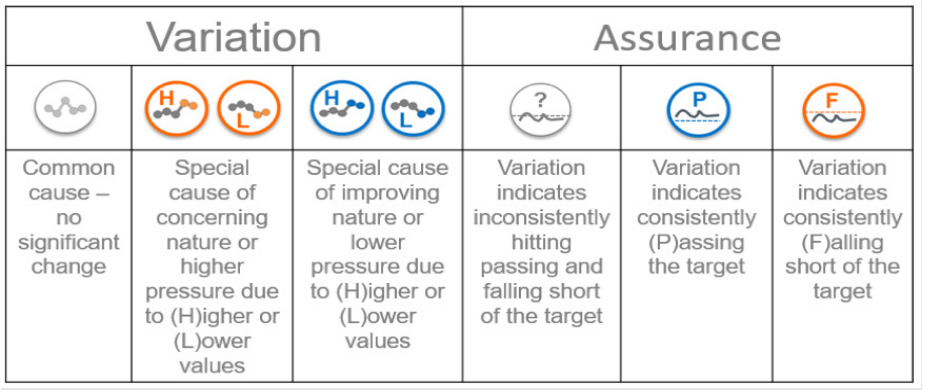
This report provides the Quality, Safety and Experience Committee with information and analysis on significant patient safety issues arising during the quarter under review, alongside longer-term trend data, and information on the safety improvements underway. The aim is to provide the committee with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

Use of data

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

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

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



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

Definitions

In October 2020, the NHS Wales Delivery Unit (DU) took on the responsibility for oversight of serious incidents on behalf of Welsh Government in anticipation of the NHS Wales Executive being formed. The Quality Directorate has regularly met with the NHS Wales Delivery Unit and will continue its strong working relationship with them.

As of 14 June 2021, NHS Wales' responsible bodies were required to implement Phase 1 of the Welsh Government's National Incident Reporting Policy. The most obvious change in policy direction is a change in terminology with the removal of the word "serious" from the term serious incident. The intention here in removing the word "serious" is to support a more just and learning culture where reporting incidents does not feel punitive.

From 14 June 2021, the following definition of a nationally reportable patient safety incident applies:

"A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare."

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

The Delivery Unit lifted any reporting restrictions that were put in place because of Covid-19 as of the 14 of June 2021.

Further details around changes to National Incident Reporting in NHS Wales can be found on the Delivery Unit website Patient Safety Incidents - Delivery Unit (nhs.wales).

Never Events are defined as patient safety incidents that are preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. The Welsh Government issues a list of incidents that are deemed to be Never Events. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have

happened because of a specific incident for that incident to be categorised as a Never Event. Information on Never Events are detailed in a separate section further in the report

NATIONALLY REPORTABLE INCIDENTS (NRI) – PERFORMANCE

During June and July 2022, 24 nationally reportable incidents were reported to the Delivery Unit. There has been no significant change in the number of reportable incidents since the previous report for April and May 2022.

The following able provides a breakdown of NRIs per health community/service:

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Health Community West: YG	2	0	2	1	2	4	1	8	0	8	1	3	0	1
Health Community West: Primary and Community	0	0	0	0	0	1	1	1	0	3	2	0	0	1
Health Community Central: YGC	0	1	4	0	2	3	3	6	8	4	5	2	6	4
Health Community Central: Primary and Community	0	0	0	0	0	3	0	1	3	1	0	0	1	1
Health Community East: WMH	0	2	1	3	0	6	4	0	0	5	0	1	1	2
Health Community East: Primary and Community	0	0	1	0	0	2	1	1	0	0	0	0	2	1
Women's and Midwifery	0	0	0	0	0	2	3	0	0	1	0	0	1	2
Diagnostics and Clinical Support	0	0	1	0	1	0	0	0	0	0	0	1	0	0
Cancer Services	0	0	0	1	0	0	1	0	1	0	0	0	0	0
Mental Health and Learning Disability	0	1	0	1	1	0	1	1	0	1	0	1	0	1
Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	2	5	9	6	6	21	15	18	12	23	8	8	11	13

The table below shows the Health Board position in terms of reportable incidents per 100,000 population in relation to the All-Wales position per 100,000 population.

Time period	BCUHB incidents/100,000 population	All wales incidents/100,000 population
Aug/Sept 2021	1.8	2.3
Oct/Nov 2021	3.8	3.0
Dec /Jan 2022	4.3	3.2
Feb/March 2022	6.2	3.8
April /May 2022	2.9	2.9
June/July 2022	3.4	2.7
AVERAGE	**3.7**	**2.9**

Given the small numbers involved, and the reporting requirements for certain incidents which can fluctuate, the average should be considered a more useful comparison than an individual two-month period.

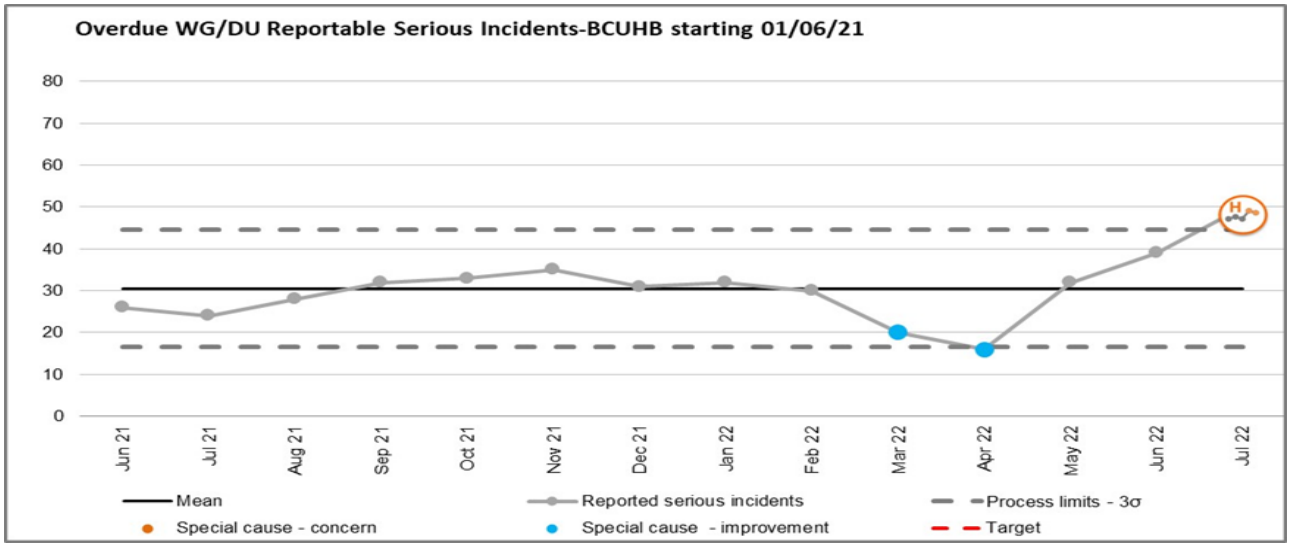
In addition to the above mentioned nationally reportable incidents, there were fifteen Early Warning Notifications (EWN) reported, nine of which were in relation to healthcare associated infections (Clostridium difficile & Covid-19 outbreaks). The other notifications relate to incidents that may attract media attention.

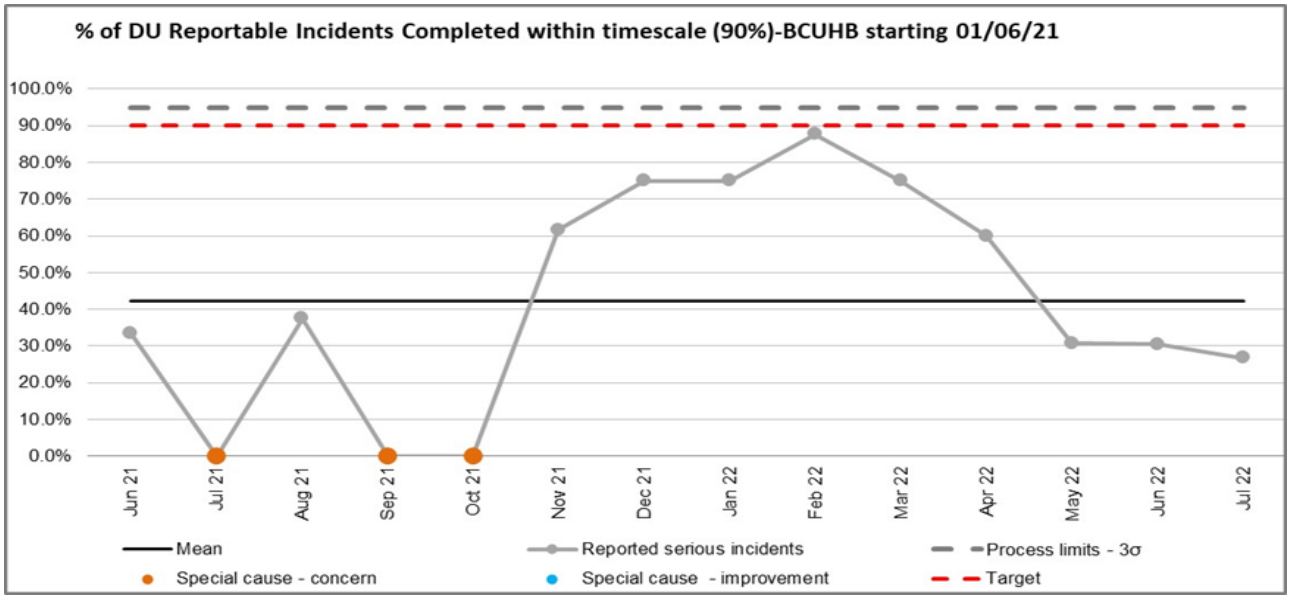
At the time of writing, the total number of national reportable incidents open is 80 of which 44 are overdue. The total number of open incidents has increased from 69 from the previous time period; the number that are overdue has increased from 32. Of the 44 incidents that are currently overdue the predominant overdue incidents sit with West Acute (14), Central Acute (13), Area Central (4). Area East have no national reportable incidents overdue, East Acute (1).

Overall closure rate within timeframe was 30.4% in June, falling to 26.7% in July. The impact on services from clinical pressures, staff sickness, vacancies, and staff re-deployment continued to impact on the ability of services to respond in a timelier manner to incident investigations. Staffing issues within the Patient Safety Team are being addressed which will enable the Patient Safety Team to better support local quality teams and services to prioritise those reports that are overdue. Weekly reports highlight the divisional performance. A report will also be produced to identify those historic incidents that are exceptionally overdue, and share will divisional management teams.

Ongoing issues with the new RLDatix Cymru system introduced in April 2022 have been resolved which will also help in improving the position. These issues impacted on performance of NRI completed within timescale as users familiarised themselves with the new system in terms of monitoring and tracking. There is confidence that a better position in terms of performance will be reported in the next period.

In the immediate term, recognising the delays to full investigations, the Patient Safety Team are placing particular focus on ensuring Make it Safe Rapid Reviews are completed so that early learning to improve safety is identified and implemented.





NATIONALLY REPORTED INCIDENTS (NRI) – LEARNING

There were 24 NRIs, for the two-month time period covered in this report. The NRIs recorded during this period can be broken down as follows

- Fall with severe harm (n=9)
- Grade 3 or above healthcare associated pressure ulcer develops (n=4)
- Unexpected death of patient not known to mental health services (n=2)
- Never Event – Wrong implant prosthesis (n=1)
- Delay or failure to monitor patient (n=2)
- Delay in treatment (n=1)
- Delay in diagnosis (n=1)
- Neonatal death (n=1)
- Maternal death - (n=1)
- Medication error (n=1)
- Other (n=1)

All NRIs are subject to a Make it Safe Rapid Review, potentially a Rapid Learning Panel and a proportionate investigation. The learning and actions from each are recorded on the Datix safety management system.

Rapid Learning Panels (RLP) take place between the senior service team and clinical executives as soon as practicable following a Never Event and/or when an adverse incident where significant harm or death of a patient has occurred. The role of these meetings is to review immediate learning and actions being taken (including any cross-Health Board immediate learning), identify key risks and provide support where required. These compliment the Make it Safe (MIS) Rapid Review completed within 72 hours and the investigation completed within a specific proportionate timeframe (30, 60 or 90 working days). During June and July 2022, 10 RLP meetings took place into the most serious incidents.

The Incident Learning Panel (ILP) was introduced as part of the new Incident Management Process in April 2021. The role of the panel is to moderate and ensure that we are constantly improving the quality of investigations and reports. All investigations into serious incidents that have occurred since April 2021 have been reviewed at the ILP. There has been an initial focus on the quality of reports by the panel and services have taken on feedback provided with a subsequent marked improvement noted. During the months of June and July 2022, 77 investigation reports were presented to the ILP. This included those investigations commissioned that do not meet the national reporting threshold.

In total there are 235 investigations in progress across the Health Board that have been commissioned by the Patient Safety Team. In total, 82% of these are over overdue. There has been a significant increase in the percentage of overdue incidents from 60% in the previous reporting period. West Acute hold the largest proportion of overdue incidents, followed by Central Acute and MHLDS. In addition, to ensure that learning is captured at the earliest stage possible, all incidents graded moderate and above are reviewed daily; and where a Make its Safe Plus review is commissioned these are reviewed at corporate level to ensure learning is captured and appropriate to promote patient safety.

The sharing of learning from incidents (beyond the immediate service) is achieved through clinical governance/quality meetings and networks, and through safety alerts where appropriate.

The system sharing and embedding of learning remains a risk for the organisation (and is contained on the Board Assurance Framework). Plans are in place to strengthen the extracting, sharing, and embedding of learning to include:

- Learning on a page to replace the “lessons learned “template re-named Insight
- Monthly ILP Bulletin serving as a compendium of all the Insight reports
- A central Patient Safety Learning Library as part of the new Intranet site
- Mandated Learning Events (using the Oxford Model Event concept) following each completed investigation
- Updating the Safety Alerts Policy and process

Themes identified from Nationally Reported Incidents

The Patient Safety Team monitor incidents to identify themes and where these need to inform organisational priorities (recognising full investigations are underway). Currently, the following are the identified themes:

- Recognition and escalation of deteriorating patient
- Falls
- Healthcare acquired pressure ulcers (HAPU)
- Surgical safety

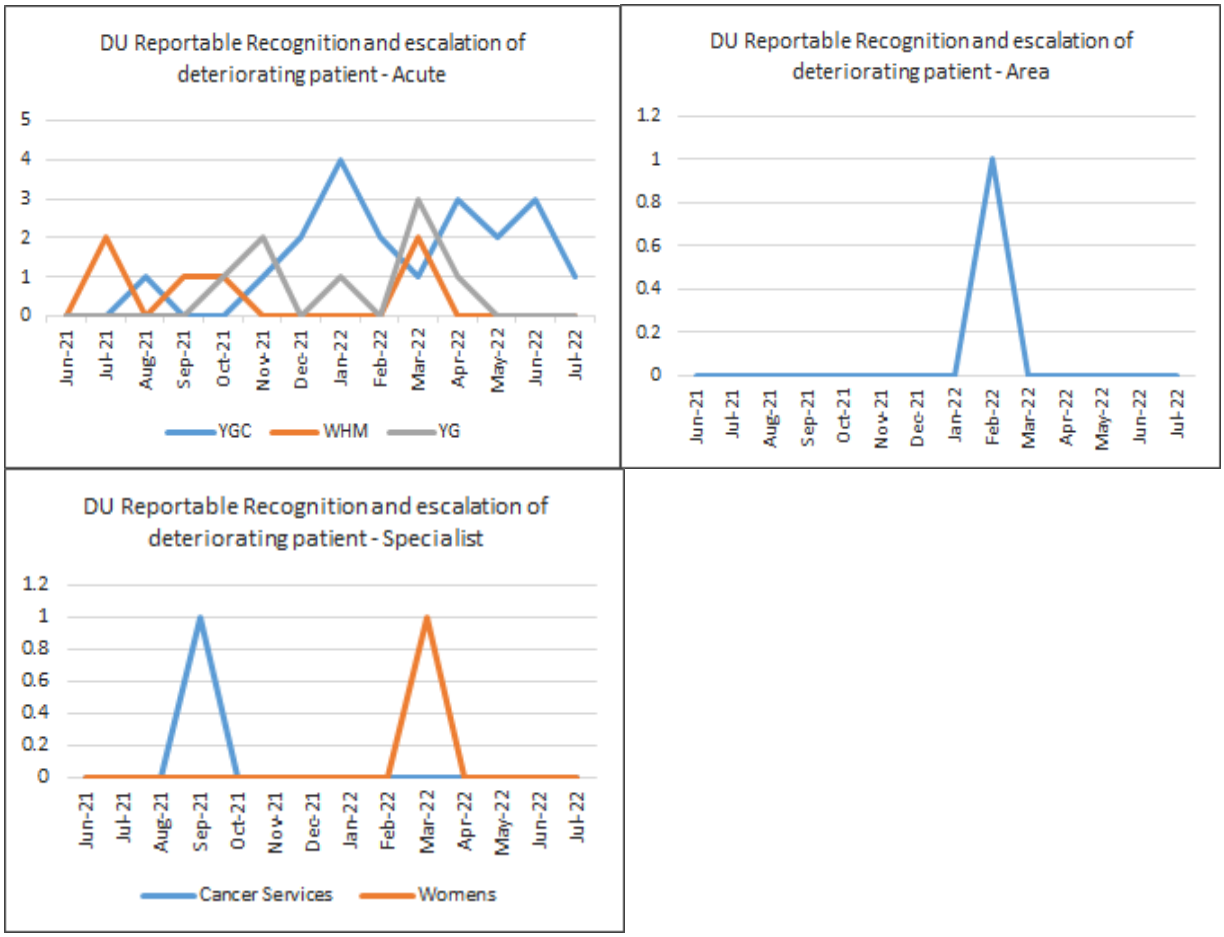
These four theme areas are underpinned by a recurring issue of record keeping, that whilst not directly causal to an incident occurring, is contributory to the circumstances that create unsafe conditions.

These five areas form the priority projects to be taken forward as part of the Patient Safety Programme which is detailed below. The charts below show the spread of where the incidents occurred per division.

The following section provides a summary of some of the themes and the actions underway.

<u>Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms and delay in diagnosis (n=4)</u>

There have been four incidents that were nationally reported during this period whereby recognition, escalation and treatment of a deteriorating patient has been delayed and subsequently resulted in severe harm or death. All four occurred in Ysbyty Glan Clwyd
Over the last year, the following related incidents were reported as NRIs:



In respect of improvement, work, this will be further refined as part of the new Patient Safety Programme. Update on work already underway is detailed below

The Health Board has re-formed an improvement group to look at one aspect of this area. The recognition and response to patients who are unwell or who deteriorate is of key importance in improving patient outcomes. The Sepsis Trigger, Escalation and Antibiotic Stewardship Review (STEAR Group) was set up in March 2022 to investigate the rapidly changing environment of Sepsis recognition, and to then improve the process of auditing Sepsis management across the Health Board through a task and finish process.

The group has had to appraise the development of new early warning scoring systems given the current ongoing reliance of the now outdated NEWS score (2012). The NEWS+ score will now include the important variable of the patient's conscious state, which is an important parameter in predicting outcome in the septic patient and as such forms part of the Sepsis 3.0 definition.

Sepsis specific interventions need to be introduced in a timely manner, however the latest statement from the AoMRC (Academy of Medical Royal Colleges) highlights that not all patients require immediate antibiotic administration, and the impact of antibiotic usage was having on antimicrobial resistance (applicable to North Wales). The AoMRC Statment tasks health care institutions with modifying their escalation process to account for this, in essence to ensure that “the right patient is getting the right treatment at the right time”. Considering this the group has agreed to adopt the amber and red escalation pathways as outlined by the UK Sepsis Trust.

Current difficulties lie with the implementation of a transformed pathway into the growing number of computerised medical notes systems (e.g. Symphony) and medical data collection systems (e.g. Medicus) who already have scoring and sepsis pathways embedded. These are currently being investigated to see if a new pathway can be entered.

The agreed pathway will then need to be established into practice with a new educational drive and a clear and uniformed strategy to audit the uptake and implementation on all sites.

A pilot in July 2022 took place in Ysbyty Glan Clwyd as part of the work lead by the Assistant Medical Director around Medical Emergency Treatment (MET) calls. During the pilot, the medical registrar would attend arrest calls but did not attend MET calls unless the responding team escalated to them. Evaluation is ongoing but subjective feedback is encouraging and positive.

In addition, an Acute Intervention Team (AIT) task and finish group, lead by the Deputy Executive Nurse Director has completed their baseline assessment. Priorities have been identified such as review of operational standards, development of a competency framework for AIT team and standardisation of deteriorating training sessions.

Deteriorating patient training sessions are being held monthly for all health communities. Good uptake for these sessions has been noted. All sessions have standard objectives

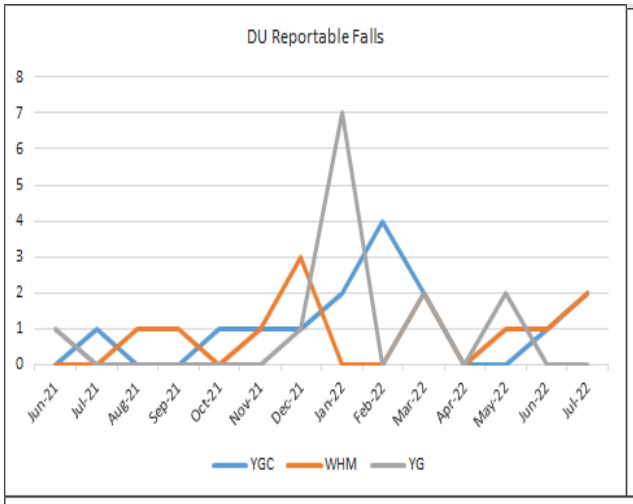
Falls (n=9)

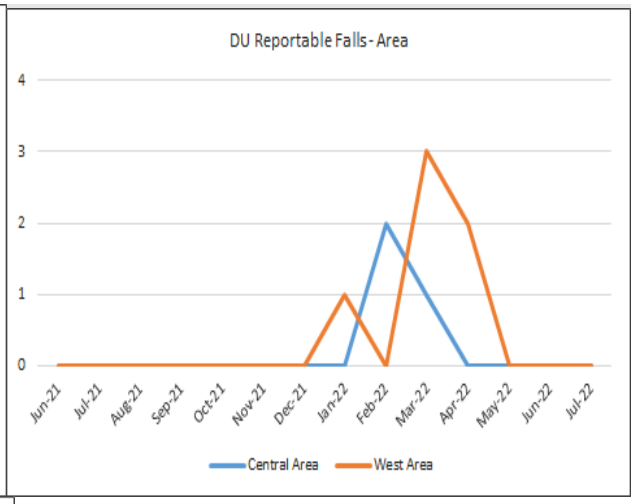
Within the reporting period there were a total of 9 patient falls that resulted in severe/permanent harm and therefore met the criteria for national reporting. This is broken down as follows:

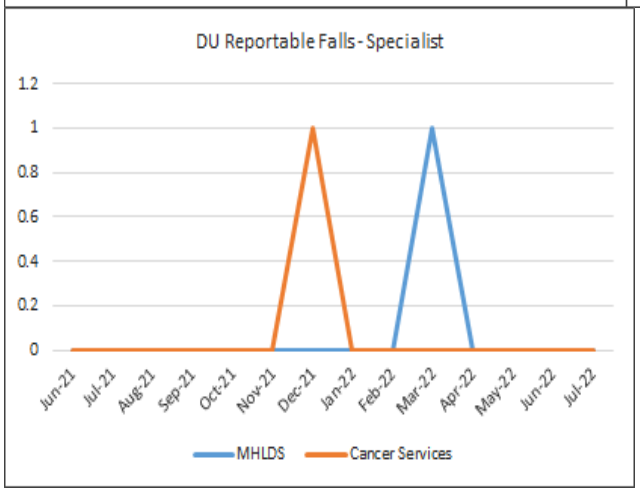
East Acute (4), East Area (3), Central Acute (2)

This is a slight increase from the previous period where the number of falls reported was 6.

Over the last year, the following rates of falls were reported as NRIs:







On review of initial learning from these incidents, there are ongoing themes that can be identified that contribute to these falls:

- Staff shortages
- Inadequate completion of falls documentation
- Poor handover/communication between staff or with families
- Lack of use of call bells
- Reliance on alarm equipment
- No lying and standing BP taken.

Immediate actions include localised training and the increasing of awareness through sharing incidents details. The impact of this awareness and training is then monitored and measured through the ward accreditation process.

There were 3 investigation reports relating to falls during this period that were approved following a review at the Incident Learning Panel.

An update from the Health Board Falls Strategic Group is detailed below

- Current Compliance rates with falls E learning overall are: Falls Module 1a 73% and Falls Module 1b 71%.
- A self-assessment tool has been developed by the Corporate Nursing Team with falls leads in readiness to support the Health Communities understand how they are performing against the Falls Policy NU06 that was launched earlier this year. This will

also be used as part of the Falls Strategic Group as routine reporting mechanism for the new Health Communities.

- The Health Communities Improvement Collaborative approach to harms reduction and patient safety has been approved by the Health Board Executive Team as the way forward for embedding and sustaining improvement. The first workshop has taken place on 21 July 2022 with 45 attendees via Teams. This workshop will be repeated in August for collaborative members who were unable to attend the launch day. Dates are set for the Falls Collaborative Masterclass 1 to commence in September 2022.
- The Corporate Nursing Team (in collaboration with Health and Safety colleagues) developed a Bedside Learning model in early February 2022 which led to a test of change with several wards identified in Secondary Care. The IHI Model for Improvement was used for testing this approach. 4 models were tested using PDSA. A suite of tools were developed to support PDSA 1 using an MDT approach for bedside learning. The bedside learning sessions were in a coaching style of conversation with staff members using a reversed psychology approach i.e. showing poorly completed Risk Assessment documentation, asking staff questions that included using the Risk Assessment as standalone documents to care for the patient safely etc and then using a well completed Risk Assessment. Each coaching sessions lasted between from 10 to 20 minutes depending on the individual. Throughout the bedside learning session, the staff members were encouraged to be curious and ask questions on a one to one to basis where they would be reluctant to ask in a classroom setting with their peers. For the fourth PDSA approach, the Corporate Nursing Team competed in depth training with Ward Managers on each of the wards in the form of a Train the trainer approach, therefore creating a hybrid approach to training. This PDSA was completed over a 4 week period and consisted of staff from Corporate Nursing and Health and safety attending the wards daily for periods of up to 2 hours at a time to capture staff on duty.
- The three wards involved in PDSA 4 were visited by the HSE on the 18th May 2022. During the visit, the improvement in Risk Assessments was noted. The discussion the HSE had with nursing staff on duty highlighted that there had been a significant improvement since the previous visit in November 2021. The HSE felt there was room for improvement (in particular Patient Handling Risk Assessments). The HSE endorsement of the model did include the need to move with pace and quality of the bedside learning across the Health Board. For each health community a bedside learning roll out plan with time scales will be developed however the Committee should note that the pace will be determined by the committed resource for the bedside learning. The health economies have had their initial meeting and are in the process of developing their implementation plans.
- The joint Community Falls Project between the Health Board and WAST colleagues in East Area has given positive results in the reduction of patients requiring conveyancing to the Emergency Department for care. This project has been tested in Central Area with similar positive results in a brief period. Please note due to funding challenges this is unable to continue in the Central Area beyond 31 July 2022.
- The business case for the proposal of a Falls MDT per health economy is in the initial stages of development.

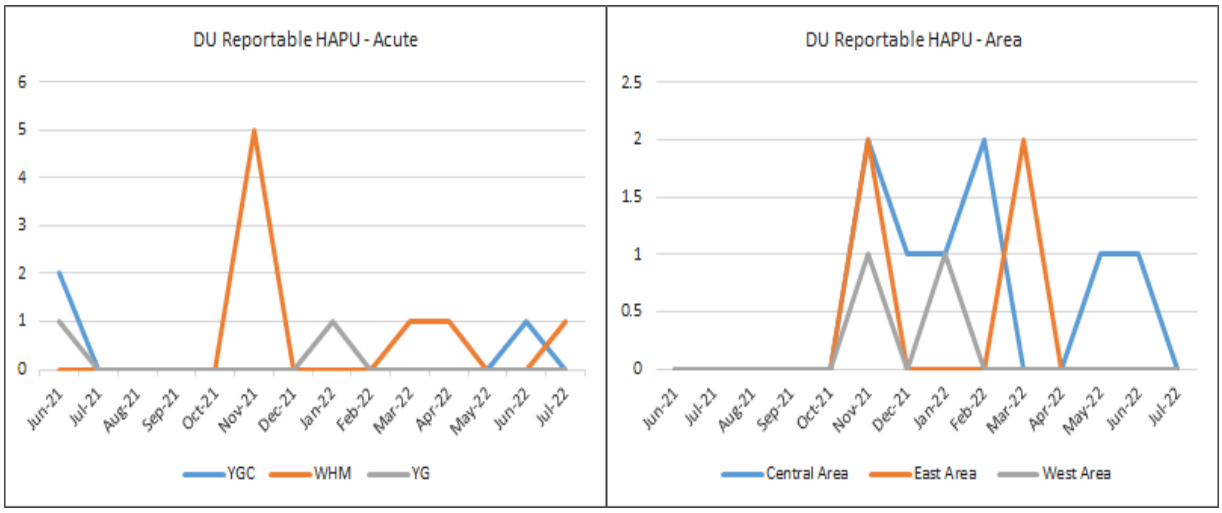
Issues continue with the extraction of data from the Datix system not pulling through into the Health Board data warehouse. This is a national issue with no fixed timeline available. Dashboards have now been created to allow live updates via the Datix Dashboards module. The Data Includes Falls, Medication, Pressure Sore, and all incidents. All users will have access. A training session is to be arranged.

Grade 3 or above healthcare associated pressure ulcer (n=4)

Within the reporting period there were a total of 4 grade 3, grade 4 or ungradable healthcare associated pressure ulcers reported to the Delivery Unit. This is broken down as follows:

Acute Central (1), Acute East (1), Area Central (1) and Area West (1)

Over the last year, the following rates of HAPUs were reported as NRIs:



The recurring themes are:

- No evidence of increasing intentional rounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation

All investigations from pressure ulcer investigations are reviewed weekly at local harms meetings. In addition, the sharing of findings at local level is reflected through the raising of awareness at safety briefs. The impact of the increased awareness is then monitored and measured through the ward accreditation process.

There were 9 investigation reports approved at ILP relating to reportable, avoidable pressure ulcers during this period. Themes and trends have been identified, which are as follows:

- No evidence of increasing intentional rounding as/when needed.
- A delay in completing documentation on admission i.e., pressure ulcer management plans and Purpose T documentation.
- Lack of reviewing and updating risk assessment documentation for patients throughout their care.

When looking at Intentional Rounding (IR) as a theme alone, the ILP has identified issues with IR to include inconsistency, gaps in IR, variation in frequency, issues not identified

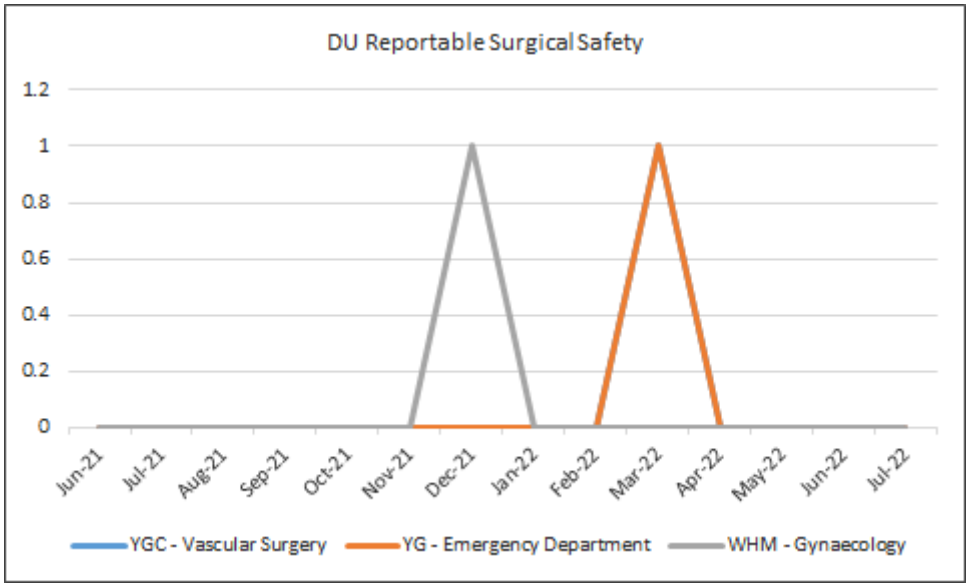
despite IR and lack of knowledge and training. As such the ILP has recommended the following:

- Review guidance and documentation regarding IR.
- Establish IR training and education.
- Ensure that registered practitioners are accountable for IR.
- Consider implementation of senior nurse/matron rounding.

The Health Community Improvement Collaborative approach to harms reduction and patient safety has been approved by the Health Board Executive Team as the way forward for embedding and sustaining improvement. The first introductory workshop has taken place on 21 July 2022 with 45 attendees via Teams. A further repeat introductory workshop is scheduled for 10 August 2022, and the first HAPU improvement group is scheduled for 25 August 2022 where measures and outcomes will be agreed, with the HAPU Collaborative Masterclass 1 to commence early September 2022. A toolkit is being developed to support the collaborative HAPU approach, which will be introduced at the improvement group in August. Baseline data is being collated for each Health Community. There will be three key focus areas per health economy: ED, inpatients, and community including care homes.

Surgical safety

Over the last year, the following rates of surgical safety incidents were reported as NRIs (excluding never events which are detailed in the specific section later o the report):



In response to the number of surgical safety incidents (including Never Events), and the learning identified, the Health Board recognised the role of human factors in the prevention and mitigation of systemic failure on patients, families, and clinical staff. The Health Board aims to mainstream human factors knowledge, understanding and practice to ensure the consistent, sustainable delivery of safer care for patients, whilst supporting our staff in that delivery: *making it easy for them to do the right thing.*

To do this, the Health Board has (1) commissioned an external company with human factors expertise, AQuA, to build capacity and capability in human factors and its application to

healthcare and training for cohort 2 (of 3) has commenced, (2) commenced the development of an organisational wide faculty dedicated to human factors, and (3) commenced a targeted programme into the surgical safety checklist.

To support (3) the Transformation and Improvement Directorate has recruited a Quality Improvement Fellow (which is a substantive member of the Patient Safety Team continues with their secondment.

Ongoing work includes a review of the current WHO Checklist process at Ysbyty Gwynedd and Ysbyty Wrexham Maelor, as well as benchmarking with external NHS providers and external visits have been conducted by the QI Fellow to further support this work. The checklist is currently at version 5 and now has a PDSA/roll-out plan established for the month of August 2022.

Examples of the main modifications and enhancements are:

- The 'Pause – Pre-Brief' element has a been re-located to the reverse of the checklist to provide greater space for the 'Sign In, Time Out and Sign Out' elements. This further provides a greater amount of free text space to document crucial information.
- Allergies and essential information such as 'All activity to STOP' are in highlighted in red.
- Theatre staff must be made aware of any expectant staff joining the team who may be absent for the crucial pre-brief stage – upon joining the team they must also be sighted on the shared plan.
- Addition of the 'Speak up for patient safety' statement to be verbalised at the end of each pre-brief session.
- A 'round the room check' to ensure staff can raise anything prior to sending for the patient.

The presence of the QI Fellow and the engagement and drive of the WHO Improvement Group has undoubtedly renewed focus on the importance of full staff engagement and compliance with the checklist. This has yielded positive quantifiable results:

Learning from other key incidents not associated with the themes (n=5)

Delay in diagnosis of cancer

A patient was referred by their GP to Cancer Services with concerns of abscess in left axilla. A lump at the same site had previously been excised in a Minor Injuries unit (MIU) in 2016. Unfortunately, the histology was not followed up by the treating doctor nor cancer services when histology became available. The result in 2016 showed a mucinous adenocarcinoma. The new presentation is therefore a missed cancer that has re-occurred. In response, the following actions are being taken forward:

- Clinical lead for MIU updating clinical pathways for all MIUs to include a directive that any staff member obtaining bloods or swabs are to take accountability for reviewing these result.
- All positive pathology results are now emailed to central cancer services inbox and actioned by co-ordinator if MDT listing not received.
- Learning points and responsibilities for checking results of tests ordered, to be shared with all doctors within central area

Ambulance delay

A 999 call was received to attend to the patient who was reported as having suffered a possible cerebrovascular accident (CVA). At 14:53 hours WAST requested for an Emergency Ambulance to be released that was delayed in handing over a patient to the ED at Wrexham Maelor Hospital, this request was declined. The WAST Clinical Contact Centre (CCC) made three welfare checks over the coming hours. On the third welfare check the call was upgraded to a red call as the patient was reported as not breathing. Eventually, an ambulance attended the scene and conveyed the patient to the Countess of Chester Hospital at 19.34 hours. Sadly, the patient shortly after arriving at the hospital

In response, the following actions are being taken forward:

- Embed use of Ambulance Assessment Room to allow patients who are waiting on ambulances to be reviewed and have diagnostics arranged at earliest opportunity.
- Communication to Clinical Site Management Team to reinforce their responsibilities in response to the red escalation when activated as well documenting the actions they took at the time.

Medication Error

The patient opted for medical management of ectopic pregnancy; methotrexate was administered. Post administration of methotrexate, B-hCG levels were monitored on the, a 12% drop was documented. Patient presented at the Emergency Department in Glan Clwyd Hospital complaining of abdominal pain. Following her admission to the Gynaecology ward arrangements were made to transfer her to theatre for surgical management. A laparoscopic right salpingectomy was performed, and the surgical findings were that of a large ruptured right ectopic pregnancy with 1000mls of blood in the pelvis. The investigation review panel agreed there were issues with the patient's follow up care (blood sampling was performed on the wrong days) and agreed that there was a delay in reviewing the b-hCG results, however this was unlikely to have changed the outcome of the patient requiring surgical intervention and salpingectomy.

In response, the following actions are being taken forward:

- The correct completion of the admission paperwork to be highlighted to both Nursing and Medical staff.
- Ward Manager to monitor through notes audits.
- Standard of all documentation to be audited monthly.
- All Nursing staff to attend an update tutorial on the use of Methotrexate.
- Task and Finish group to review the documentation to be arranged.

Failure to follow up (Ophthalmology)

A patient was being treated for wet age-related macular degeneration (wAMD). As disease was active, the patient needed re-treatment in 4 weeks. Next appointment delayed due to capacity issues until 6 weeks overdue and the patient presented with a massive subretinal bleed. Vision had dropped from 0.12 (6/9= driving vison) to <6/60 (no letters on standard chart). The investigation concluded that the six weeks delay the patient experienced in receiving treatment was attributable to the reduced numbers in all clinic capacity. This was

a direct result of reduced clinic templates and reduced waiting room capacity due to social distancing. The harm caused to the patient's vision was unavoidable due to lack of capacity within the service.

In response, the following actions are being taken forward:

- Develop a Standard Operating Procedure to address the recording of the patients on the waiting list.
- Eensure utilising WPAS as the predominant method of managing patients on the waiting list and attendance.
- Undertake a Clinical Risk Assessment on social distancing measures at Abergele Hospital to increase face to face clinic appointments.
- A review of overdue follow-up appointments from the April 2019 to provide assurance no further patients are lost to follow-up and assess the numbers who may be overdue and by how long.
- Urgent additional clinics led by Clinical Fellows in the first instance to be arranged to increase capacity - likely to be run at the weekend/twilight.
- Business case for a Speciality Glaucoma Doctor and position filled by August 2022.

Ambulance Handover delay

Following a delay of 17-hour in the ambulance outside Ysbyty Glan Clwyd the patient was finally admitted to the Emergency Department (ED) resuscitation area. The patient was swiftly taken to the surgical department and transferred to theatre The patient underwent extensive abdominal surgery and was transferred to ITU, but sadly died a brief time after.

The overarching cause of this incident was the extensive pressures placed on the ED staff by the department being significantly overstretched with additional patients waiting in ambulances.

In response, the following actions are being taken forward:

- A reflective review with all triage nurses to emphasise the importance of escalation and the importance of reviewing the patient from their first contact with the ambulance crew to the time of triage.
- Teaching package for this incident used highlighting the importance of sepsis screening and looking back at the observation data collected in from the paramedic crews.
- A reminder to WAST staff of the importance of full NEWS scores.

Delay in transfer of patient

The patient presented to the Emergency Department with symptoms of a Stroke. He received prompt and appropriate treatment and following discussion with The Walton Centre a Tertiary Neurology referral centre he was accepted by them for a thrombectomy procedure. A request for an immediate transfer was made by the ED to WAST to convey the patient for this urgent time critical treatment. Due to demand in the community and protracted waiting times to off load ambulances in ED across the region WAST was unable

to facilitate an immediate transfer. When a vehicle became available at 04:57 unfortunately by this time The Walton Centre advised against transfer until a further CT scan had been performed. Following the repeat scan, it was determined that a thrombectomy was no longer the best treatment option for the patient and he remained in Wrexham Maelor.

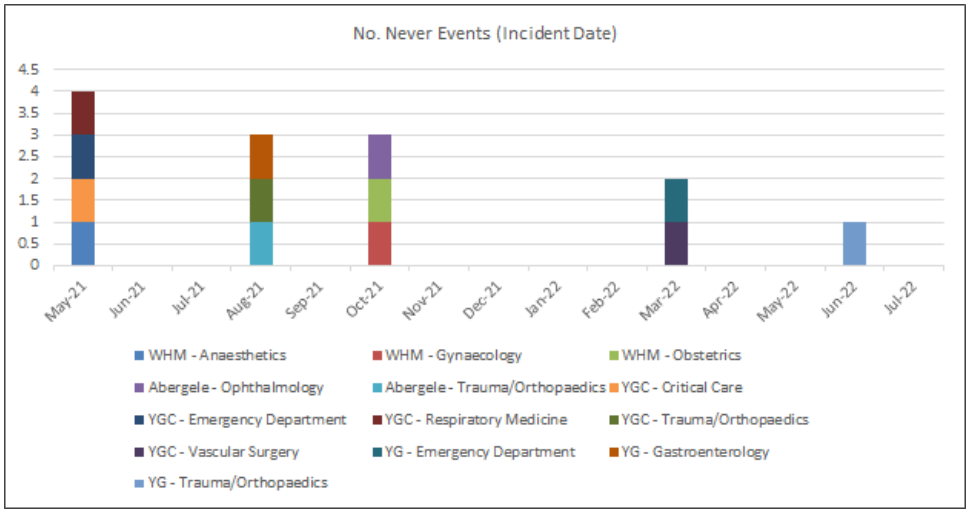
In response, the following actions are being taken forward:

- Development of a Pan BCU working group consisting of all NHS and external agencies involved in inter-site and inter-hospital transfers for time critical procedures.

NEVER EVENTS

In the current financial year, April to July 2022/23, one never event has been reported, compared to 4 in the same timescale in 2021/22.

Twelve Never Events were reported in 2021/22, compared to five in 2020/21 and six in the full year of 2019/20. Action relating to the primary theme (11 of 12 incidents) is surgical safety, which is detailed above in the learning and improvement action.



New Never Events

Within the current reporting period one new Never Event was reported, detailed immediately below. Investigations into the incident are ongoing.

Wrong implant prosthesis - patient had a Microport Evolution Medial Pivot TKR. A size 5 femoral component was inserted with a size 4 tibial tray and size 4 polyethylene insert. The surgical team and the company representative did not recognise that this was an incorrect combination, there should have been a size 4+ polyethylene insert used as recommended by the manufacturers and operative technique available in theatre.

Immediate Learning: To work with the company to understand their checking process and identify elements that the Health Board could implement into process. To also review the governance around visitors in theatres to ensure the Health Board follows good practice.

Open Never Event Investigations

The following Never Event investigations remain underway.

Incident date	Incident Description	Current status
Retrospective incident 10/05/2021	Retention of a foreign object – a surgical swab found within the patient's throat following a theatre visit.	The investigation is in the final stages.
20/08/2021	Ascetic drain inserted inappropriately. Consent taken from patient as intended to relieve respiratory symptoms.	Rejected at ILP – more robust action plan required.
13/10/2021	During laparoscopy for ectopic pregnancy, healthy tube removed prior to visualisation of rupture tube containing pregnancy.	Rejected at ILP – awaiting action plan.
06/03/2022	Wrong site surgery – patient taken to theatre for a femoral - popliteal bypass but received a femoral - femoral bypass only.	Investigation complete. Currently with vascular team for accuracy check
18/03/2022	Wrong site surgery – Patient taken to theatre for laparotomy and litigation of right iliac artery. Further exploratory laparotomy undertaken where the surgeon removed vicryl tie around left common iliac artery.	Local investigation complete; awaiting release of report from external vascular reviewer.
22/06/2022	Wrong implant prosthesis - patient had a Microport Evolution Medial Pivot TKR. A size 5 femoral component was inserted with a size 4 tibial tray and size 4 polyethylene insert, instead of the recommended size 4+ polyethylene insert	Investigation ongoing

INDEPENDENT INVESTIGATIONS

There is currently two independent external investigation ongoing as commissioned by the Health Board:

Location	Incident	Update
CMHT (East) MHLD	Patient known to Community mental	Final report with service and action plan being developed.

	health team arrested on suspicion of murder	
Childrens Services (Central)	Death of child shortly after transfer to Alderhey after admission through ED and surgery in YGC.	External Investigating Officer identified and review ongoing.

Additionally, a thematic review into a cluster of major obstetric haemorrhages is due to completion and will be detailed in the next report.

PATIENT SAFETY IMPROVEMENT PROGRAMME

The Quality Directorate are currently working closely with the Transformation and Improvement Directorate to develop a **Patient Safety Improvement Programme**. A workshop was held on 07 February 2022 led by the Associate Director of Quality. All medical, therapy and nursing directors were invited, and the aim of the workshop was to work through priorities for the projects (approximately 4/5 per year) focused on preventing or reducing harm. The recommendations were presented at a meeting with the Executive Clinical Directors and a paper on the programme structure is being drafted for submission to the Executive Team.

These five priority projects proposed, linked to the themes that are highlighted in this report, are:

- Deteriorating patient
- Falls
- Healthcare Acquired Pressure Ulcers (HAPUs)
- Surgical Safety
- Clinical documentation

PATIENT SAFETY ALERTS AND NOTICES

The Welsh Government (WG), supported by the NHS Wales Delivery Unit, leads on the vital role in identifying significant national safety risks and concerns that would require a Patient Safety Solution at a national level for issue to the NHS in Wales. There are two types of solutions issued:

- ALERT (PSA): This requires prompt action with a specified implementation date to address high risks/significant safety problems.
- NOTICE (PSN): This is issued to ensure that organisations and all relevant healthcare staff are made aware of the potential patient safety issues at the earliest opportunity. A Notice allows organisations to assess the potential for similar patient safety risks in their own areas and take immediate action. This stage ‘warns’ organisations of emerging risk. It can be issued in a timely manner, once a new risk has been identified to allow rapid dissemination of information for action.

Organisations are required to confirm that they have achieved compliance by the date stated.

Open Alerts

Reference	Title	Applicable To?	Type	Date action underway	Deadline	Notes
PSN057	Emergency Steroid Therapy Cards: Supporting Early Recognition & Management of Adrenal Crisis in Adults and Children	BCU-wide	Patient Safety Solution - Notice	27/05/2021	31/12/2021	Clinical policy progressing through approval process.

Closed Alerts

PSN058 - Compliance submitted 23/06/2022 - Urgent assessment/treatment following ingestion of super strong' magnet.

DATIX CYMRU

The new Datix Cymru system was launched across the Health Board on 01 April 2022. This system is in use across Wales and aims to bring consistency to reporting across all Welsh Health Boards and Trusts.

The Datix Implementation Team have been working to a clear project plan and provided significant training opportunities and extended helpdesk support during implementation.

As with the introduction of any new system, there were issues and challenges that evolved. Initial issues included:

- Access to Datix: Issues have been resolved as over time the implementation team have amended permissions and/or "location exact" for users to access all reported complaints and incidents in specific user areas of responsibility and the team continue to monitor.
- Due to continued reporter error of Location and Service data validation is carried out by the Datix support team each morning to ensure user access.
- There are some ongoing issues such as the Mortality process and system flow that does not follow the Health Board process. Members of the Datix Implementation Team are attending Once for Wales task and finish group to match the framework to the module.
- Migration of open Incidents, claims and inquests is ongoing from the Datix web system and is on track for completion by the end of August 2022.
- Necessary changes to the PALS module have now been agreed nationally; PALS will go live on 31 August 2022.

There are no fundamental issues remaining for escalation to the committee; however, as a new national project with ongoing development and further projects, the continued development and roll out is being carefully supported and managed locally.

Datix Training

A training schedule is available weekly and can be accessed via the Datix intranet page along with user guides and training videos.

Tuesday	
Session Title	**Time**
Incident Reporter: General Inputting	10:00 - 10:30
Incidents: General Management	10:30 - 11:00

4 Weekly Rotation – Incident Inputting		**4 Weekly Rotation - Incident Management**	
Pressure Sore	11:00 - 11:30	Pressure Sore	11:30 - 12:00
Falls	11:00 - 11:30	Falls	11:30 - 12:00
Medication	11:00 - 11:30	Medication	11:30 - 12:00
Aggressive Behaviour	11:00 - 11:30	Aggressive Behaviour	11:30 - 12:00
Safeguarding	11:00 - 11:30	Safeguarding	11:30 - 12:00

Thursday	
Session Title	**Time**
Datix Cymru Reports - Query Set Up	10:30 - 11:00
Datix My Reports Training	11:00 - 11:30
Dashboard Set Up Training	11:30 - 12:00

NHS WALES DELIVERY UNIT REVIEW

The Health Board asked the Delivery Unit (DU) to undertake deep-dive assessment of its incident process.

On the 30 and 31 May 2022, Andy Long (Quality and Performance Improvement Manager) and Lee Joseph (Quality and Safety Manager), from the NHS Wales Delivery Unit (DU) Quality and Safety Team, visited BCUHB headquarters by invitation to observe a number of quality and safety functions, and provide in-person feedback on recent investigations undertaken by the Health Board.

During the visit, the DU met and discussed matters with Dr Kath Clarke (Acting Assistant Director of Patient Safety), Sarah Musgrave (Lead Manager for Patient Safety), Matthew Joyes (Acting Director of Quality), and Steven Beaumont (Acting Assistant Director of Quality).

During the visit, the DU were provided with an overview of the Health Board's incident management process, and observed several quality and safety functions. The two day agenda included the following specific topics:

- Daily Datix meeting (Observation and feedback)
- Incident Learning Panel (Observation and feedback)
- Rapid Learning Panel (Observation and Feedback)
- DU feedback following review of three recent never event investigations

The feedback report states:

“Overall, the DU feedback was highly positive with the approach, focus and quality of functions observed and discussed with the Health Board’s corporate senior team responsible for quality. There was clear evidence of a patient centred approach and focus to the Q&S agenda, with the team demonstrating positive leadership and a commitment to achieve high standards across the organisation. The Q&S team fully engaged the DU and maximised the opportunity to discuss opportunities to explore alternative methods, responding positively to all feedback and suggestions as outlined in the feedback summary below.”

“Overall it was felt that the corporate team have a good handle on the quality and management of incidents. As identified earlier, the corporate team have taken a strong quality control approach in order to improve the quality and strength of investigations. The DU feels that with investigations in the main being of a more than adequate standard, this has been achieved and that the corporate team will now be best to take more of a quality systems/processes assurance approach and devolve the quality control function, in the main, to the local teams.”

“In taking a more assurance focused approach the corporate team can place more emphasis on the identification of significant risk from single incidents or through emerging themes and trends, providing oversight on the effective assessment, mitigation and control of those risks, allowing them in turn to provide improved assurance at the appropriate levels with the HB.”

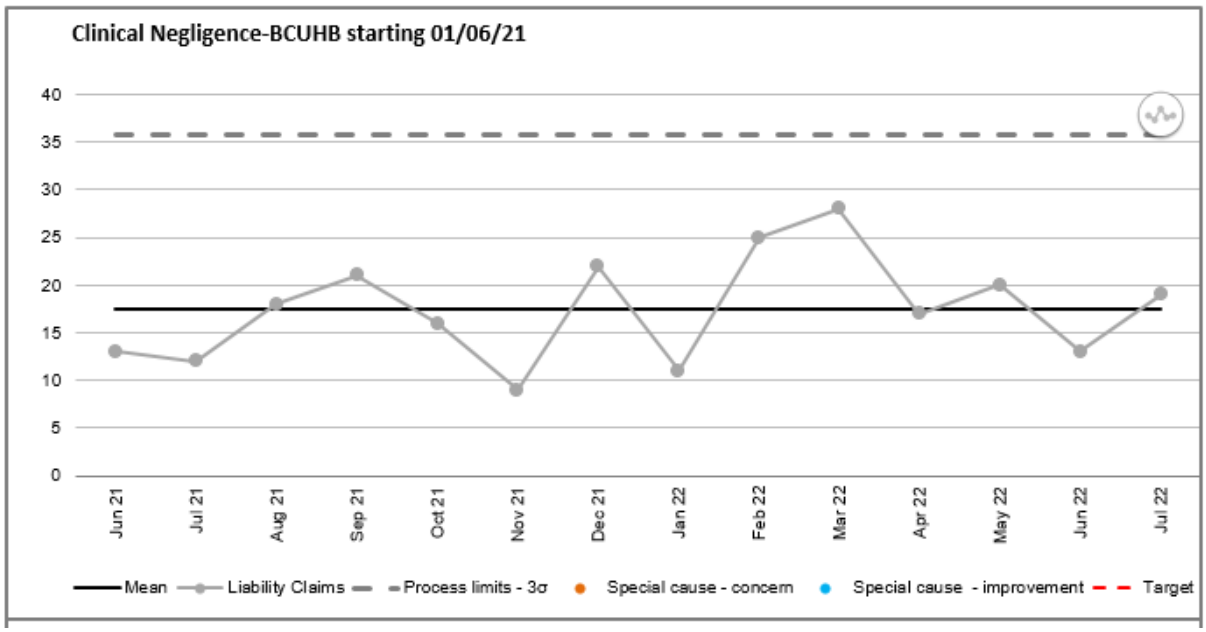
“The DU also suggested the Health Board consider developing a more collaborative approach to incident learning such as learning events, which helps teams walk through the learning process in a facilitated way. Other organisations which have adopted this practice have demonstrated this approach (where appropriate), helps reduce natural barriers to learning by addressing the human dimensions of change, by engaging the workforce in the reflection, learning, and change process required following adverse incidents. The DU offered to return and help facilitate such an event if helpful.”

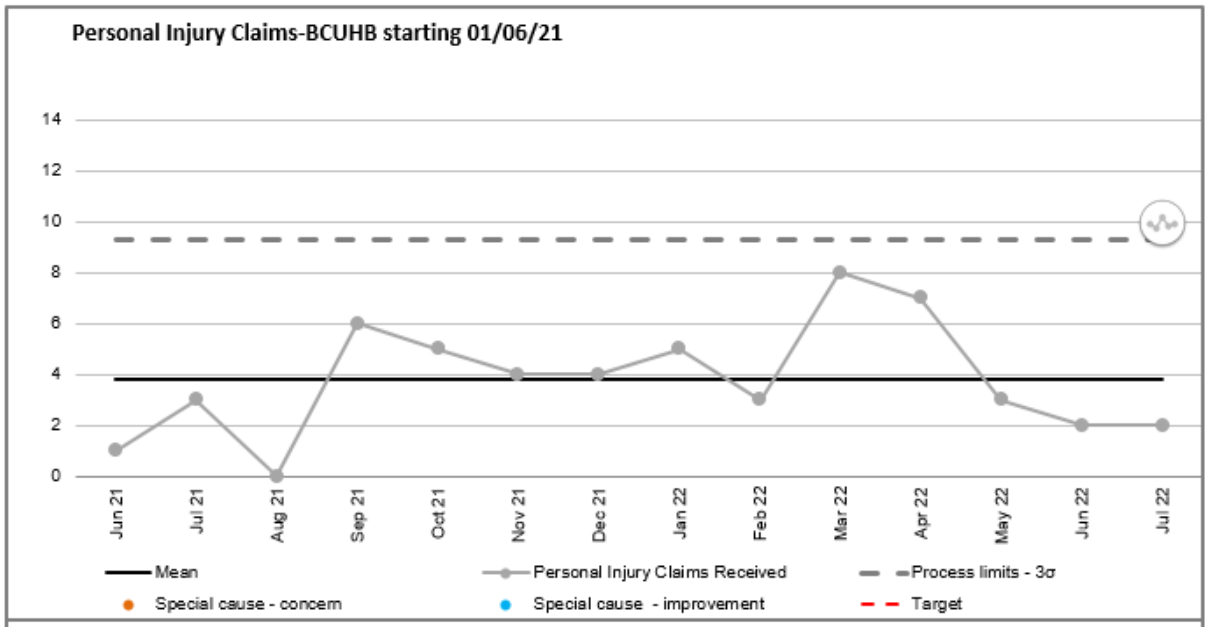
The suggestions from the NHS Wales Delivery Unit are being formed into an improvement project.

LITIGATION

During this bi-monthly period of June and July 2022, 36 claims or potential claims were received against the Health Board. Of these, 32 related to clinical negligence and 4 related to personal injury.

Whilst the numbers have fluctuated a little throughout the bi-monthly periods, it is anticipated by Legal and Risk Services (the Health Board’s solicitors) that claims will rise significantly due to the direct and indirect effects of the Covid-19 pandemic, e.g., from the effects of cancelled procedures, appointments and Covid related claims.





During the bi-monthly period, 62 claims were closed. Of these, 46 related to clinical negligence and 16 related to personal injury. This figure is high as the team have been continuing to review claims prior to migration to RL Datix and closing those that were limitation barred and dormant over 12 months. The total costs for the total closed claims in this period amounted to £2,613,842.98 before reimbursement from the Welsh Risk Pool. The most significant claims related to:

> The claim relates to a failure to undertake a Caesarean Section, which led to the Claimant suffering a left sided brachial plexus injury at birth. (£1,247,895.50)
>
> *Learning*:

- The Directorate have a shoulder dystocia Guideline (Obs 13). Section 3 of the Guideline highlights increased risk factors for potential shoulder dystocia, supporting discussion with women and staff education and knowledge.

- All staff are reminded of the requirement for contemporaneous documentation to clearly record any discussions concerning care planning and decisions made. The Clinical Supervisor for Midwives undertakes record keeping audits.

The claim relates to a compression injury from a back slab, which led to peroneal nerve damage whilst the Claimant was in hospital. (£582,274.00)

Learning:

- We now have better hand-over arrangements in place regarding patients that need monitoring over the weekend. This includes typed handover sheets and the use of whiteboards.
- All medical staff are encouraged to attend the plaster room at induction to ensure that they are well versed with plaster application and safety precautions. The registrars and any other juniors attending have teaching in theatre regarding this. The T&O induction booklet has a list of competencies that juniors are assessed on, which includes plaster application and how to assess limb neurology. The grading of power would feature in this.
- With regards to pressure points within the cast or back slab, patients are educated to report excess pain or other symptoms and the plasters are checked often by removing them completely.
- The checking of neuro vascular status in every trauma patient is also stressed in trauma meetings every morning.

The claim relates to a delay in undergoing an MRI scan, which led to delay in diagnosing Cauda Equina Syndrome. (£154,381.89)

Learning:

- All urgent requests for MRI are vetted by a consultant radiologist and are triaged in order of clinical urgency.
- Teaching sessions are conducted on Cauda Equina and red flags within the T&O team.
- All surgical and medical wards in the hospital have been given laminated red flag Cauda Equina symptom posters that have been put up on the ward in the treatment rooms.
- With the recognition of CES, there is now a much lower threshold for requesting MRI scans.

The claim relates to a failure to interpret and report on an ECG. The aortic root was abnormal, showing dilatation with an echo-free space behind the non-coronary cusp of the aortic valve. This should have been identified. If these findings were interpreted correctly, it would have prompted urgent cardiologist review with corroborative imaging. The treating clinicians were therefore falsely reassured and were unable to reach the correct diagnosis. (£153,348.12)

Learning:

- Standards of echo reporting for suspected aortic dissection were reviewed with respect to following contemporary guidelines.
- As part of ongoing learning a weekly departmental meeting is held to discuss cases and review new practices, this includes peer reviews and sharing of information and presentations from external learning experiences and reviewing individuals' images.
- To ensure that the department keeps up to date with developments, each year staff attend the BSE Conference and the knowledge gained is disseminated to the rest of the department.
- There are other learning opportunities during the year with staff attending conferences all over the country to ensure that our practices are up to date.

This claim relates a negligently performed surgery, where the Claimant's gall bladder was removed instead of the kidney. (£155,677.80)

Learning:

- There is work being undertaken by the Quality department to establish online access to a lesson learned library – this will ensure staff have ongoing access to lessons learned from various sources such as SIR's, Mortality, PSN etc.
- Human factors orientated review of the scenario for learning and building of relationships.
- Training has been undertaken in Theatres on the debrief process and an audit of debrief documentation has been undertaken.
- Theatre staff, surgeons and anaesthetists are instructed to report unexpected blood loss or perioperative complications as incidents on Datix.
- A review has been undertaken of the process within histopathology when there are concerns as to the nature of a specimen, to include documentation of actions taken. Any specimen that does not match what is stated on the label is to be reported as an incident on Datix.

The claim relates to delay in treatment for a stroke due to ambulance delays in Wrexham ED (£195,653.14)

Learning:

- Introduction of a Rapid Ambulance Assessment area in ED.
- After many changes in the pathways of stroke since 2013, Clinicians are now pre-alerted about patients who have ongoing stroke symptoms, and they are prioritised and brought straight into the emergency department. A stoke team is on standby to accept them. No patient is kept outside and will be sent for a CT scan if they meet the eligible criteria for a possible stoke.
- A new paperless system containing a stroke assessment flow chart has been introduced.

The following themes have been identified for this period for clinical negligence:

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

As expected, the largest number of open claims relate to Surgery, Specialist Medicine and Women and Maternal Care. This is not an unusual profile of specialities within the NHS. The themes remain similar. The Health Board also continues to comply with the Early Reporting Scheme adopted in Wales in relating to potential birth injury claims.

The following themes have been identified for personal injury:

1. Slips/trips
2. Violence & Aggression

PI claims savings due to discontinued or favourable settlements for this period £131,904.12. These are financial savings for providing evidence to L&R, which allows for a denial of Health Board liability in a matter leading to a claim being discontinued or in the case of favourable settlements; we have been able to negotiate a lower compensation payment due to the investigative work of the Claims Manager (PI) and L&R.

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

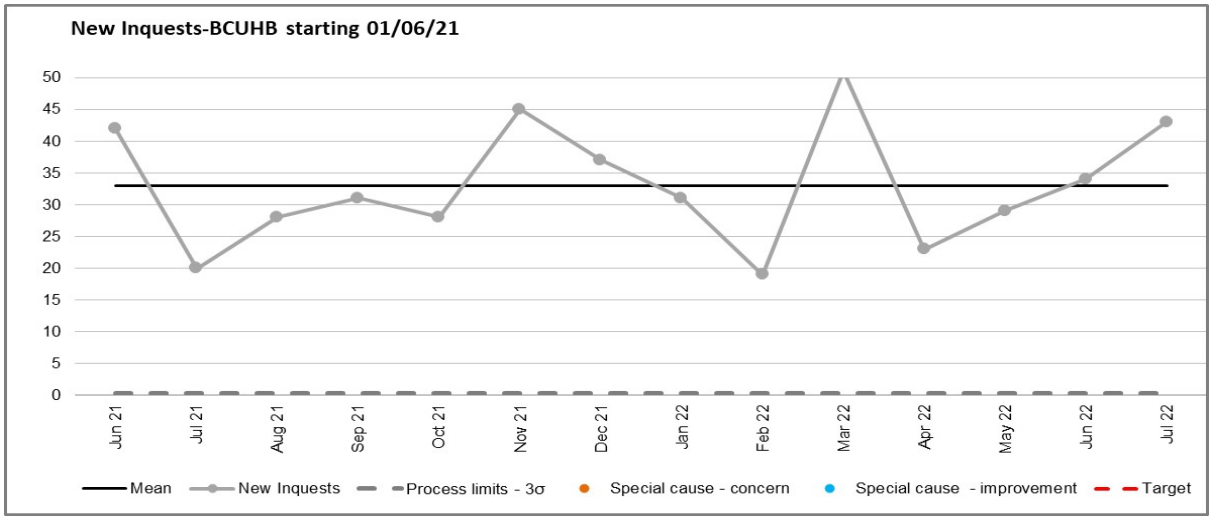
The Welsh Risk Pool (WRP) arrangements require that individual NHS bodies meet the first £25,000 of any claim or loss. Thereafter the NHS bodies can submit a reimbursement request to the WRP for consideration and approval. The WRP administers the risk pooling arrangements and meets the cost of financial losses over £25,000. All Health Boards and Trusts across Wales have been advised by the Welsh Risk Pool that the annual revenue allocation from the Welsh Government is not sufficient to meet the value of forecast in year expenditure and that it is likely additional contributions will be required. BCUHB's share of the increase will be 17.07% and the current forecast predicts an additional cost of £2.56m in addition to the contribution already made, creating a significant impact on the overall financial position. The Finance Division are aware, and it will be included as a potential risk until things are finalised later in the year. National discussions are underway; however, this figure succinctly reflects the increasing costs arising from liability claims across the NHS.

INQUESTS

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

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

During the relevant time period, June, and July 2022, 77 new inquests or requests for information from the coroner were received from the Coroners in North Wales.



53 inquests were concluded between during June and July 2022. The distribution of the inquest conclusions is in line with previous findings, and there are no unusual or unexpected findings to be taken from this.

Prior to listing the inquest hearing, the coroner may decide to hold a pre-inquest hearing. These are usually for more complex cases and often with Legal & Risk Services support and are undertaken to help identify any outstanding information required, to hear submissions and to identify which witnesses will be required to attend the inquest hearing.

There are currently 42 inquests with NWSSP Legal and Risk Services support in progress across the health board. Some are in initial stages and others are awaiting inquest date, and various stages in between.

In the period of this report, there were **no** new Regulation 28 (PFD) reports issued by HM Coroner to the Health Board,

The responses to previously received regulation 28 reports as detailed below:

1. TR: Theme – delay providing evidence of completed actions post investigation / change in working practices

Coroner's Concerns:

1. Despite earlier identification that existing working practices within Oncology (placement of report on clinician's desk) resulted in failure to treat in a timely manner, the Health Board did not fully implement a new SOP until December 2021.
2. Formal acknowledgement of new SOP by Oncology and Haematology secretaries not completed until 22 February 2022
3. Failure to have completed an audit process to assure changes were operational and effective.
4. The length of time taken to implement changes and ensure introduction and adoption of new, safe working practices presents a risk to life.

Response sent to HMC on 01 July 2022, addressing above concerns.

a. Confirmation that SOP forms part of new starters' induction within Cancer division, forms part of regular Cancer secretarial meetings and learning shared with other services.
b. Completion of 2 audit cycles of new process (May and June) undertaken to date, with improvements demonstrated by second cycle. Monthly audits now in place to feed into Cancer Services Governance meetings.
c. Update regarding, the Results Management Project – aim to integrate with WCP – ready for roll out. Plan to use Respiratory Service as early adopter service, with BCU-wide roll out by end of year.
d. Assurance given regarding scrutiny of all outstanding and overdue investigation actions as part of bi-monthly Patient Safety Report (from June 2022), to ensure visibility of action delivery performance and to enable divisions to be held to account via Governance fora and accountability review meetings.
e. Explanation of OCP process within Quality function to provide greater clarity and expectation for quality staff based locally within divisions who will operate a business partner model, providing local support at directorate and divisional level. This works links into the organisational 'Stronger Together' strategy.
f. Review of clinical audit process to closer align the audit programme with risks identified through issues such as serious incident report and inquest matters. Roll-out of new electronic audit system.

2 **RG: Theme – Ambulance delays**

Coroner's Concerns:

1. First cause of ambulance delay – all other resources already allocated
2. Delay in handover from WAST to BCUHB across all sites
3. Concern that future deaths will occur either with patients awaiting transfer into hospital from ambulance, or by ambulances not being available to meet community need.
4. These matters of concern are longstanding and despite proposed future action the concerns remain.

Regulation 28 PFD issued jointly to BCUHB and to WAST

The Health Board approached WAST regarding the possibility of providing a joint response, but this was declined.

Response sent to HM Coroner on 20 July 2022, addressing the above concerns.

a. Acknowledged HM Coroner concerns and confirmed these are shared by BCU. Ongoing impact of Covid-19 pandemic on staffing and resources with regard to achieving sustainable improvements, and the importance of recognising that improvements are not purely an ambulance or emergency department and health care issue. There are wider social care 'flow' issues, which in turn impact on ambulance and emergency department pressures.

b. Explanation of Unscheduled and Emergency Care Programme which echoes the Welsh Government six goals for urgent and emergency care, ensuring that work in North Wales is fully aligned to the government's priorities. These are: 1. Coordinated planning for populations at risk
   2. 24/7 signposting for urgent care
   3. Clinically safe alternatives to admission
   4. Rapid response in crisis
   5. Optimal hospital care and discharge practice
   6. Home first approach
c. Assurance given regarding recruitment of a programme director to drive this work forward.
d. Assurance of health board commitment to investment in the programme as well as awaiting a funding decision from Welsh Government on a 111 First scheme.
e. Explanation of projects underway for Phase 1 Unscheduled and Emergency Care Programme as well as plans for Phase 2.
f. Additional information to HM Coroner regarding workstreams associated with the improvement programme in response to the Health Inspectorate Wales identification of BCU as requiring significant improvement – including
   1. Back to basics
   2. Leadership, empowerment, culture, and OD
   3. ED, medicine, and flow
   4. Vascular and theatres
   5. Audit, outcomes, and assurance

   The improvement plan is in development with staff and stakeholders, and key work is underway of relevance to the issue of ambulance delays.
g. There will be regular evaluation of the improvement work at YGC, and depending on the evidence of improvement, will be for roll-out across the wider health board.

CONCLUSION

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

Of note, the themes arising from nationally reportable incidents (including Never Events) remains as previously reported. This includes falls, healthcare acquired pressure ulcers, surgical safety and the recognition and response to deteriorating patients. Improvement work is underway in these areas as detailed above. In particular, there is an emerging improving position in regard to surgical safety however it remains too early to draw conclusions. Ysbyty Glan Clwyd remains the site with the highest number of NRIs, and the Committee is asked to cross-reference to the improvement plan underway across the site and the appointment of an Improvement Director for Clinical Safety and Effectiveness.

The report also highlights the two Regulation 28 responses. The Committee is advised to consider the significant theme of ambulance handover delays as highlighted in the separate paper and consider what assurance it may wish to seek in regards to plans for improving patient safety in unscheduled care.

The QSE Committee is asked to note the report.

Report title:	Patient and Carer Experience Report			
Report to:	QSE Committee			
Date of Meeting:	Tuesday, 06 September 2022			
Executive Summary:	This report provides the Committee with information and analysis on significant patient and care experience feedback arising during the quarter under review, alongside longer-term trend data, and information on the improvements underway.			
Recommendations:	The committee is asked to receive this report.			
Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery			
Report Author:	Matthew Joyes, Associate Director of Quality Carolyn Owen, Assistant Director of Patient and Carer Experience Rachel Wright, Patient and Carer Experience Lead Manager Kim Warrington-Davies, Complaints Lead Manager			
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:
There is confidence in the data provided in the report however, the strength of learning and improvement remains an area of concern and is a key focus of work. As detailed in this report, work is underway to improve both the process and culture regarding patient safety and linked to this the approach to improvement.

Link to Strategic Objective(s):	Quality
Regulatory and legal implications	Considerations in this report cover compliance with the Putting Things Right Regulations and Ombudsman requirements.
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	BAF21-10 - Listening and Learning
Financial implications as a result of implementing the recommendations	Not Applicable
Workforce implications as a result of implementing the recommendations	Not Applicable
Feedback, response, and follow up summary following consultation	Not Applicable
Links to BAF risks: (or links to the Corporate Risk Register)	BAF21-10 - Listening and Learning
Reason for submission of report to confidential board (where relevant)	Not Applicable

Next Steps: Not Applicable

List of Appendices: Complaints Recovery Proposal, PSOW Annual Letter 2021-2022.

Patient and Carer Experience Report to the QSE Committee June-July 2022

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board	**Patient and Carer Experience Report April 2022 – July 2022**

1. INTRODUCTION

1.1 Patient and carer experience is what the process of receiving care feels like for the patient, their family and carers. It is a key element of quality, alongside providing safe care and clinically effective care.

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

1.3 The Health Board has responsibilities for improving patient experience under the following key statutory responsibilities and policy frameworks:

- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
- Healthcare Standards for Wales (Welsh Government, 2015)
- Wellbeing of Future Generations (Wales) Act 2014;
- Social Services and Wellbeing (Wales) Act 2014;
- Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)

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

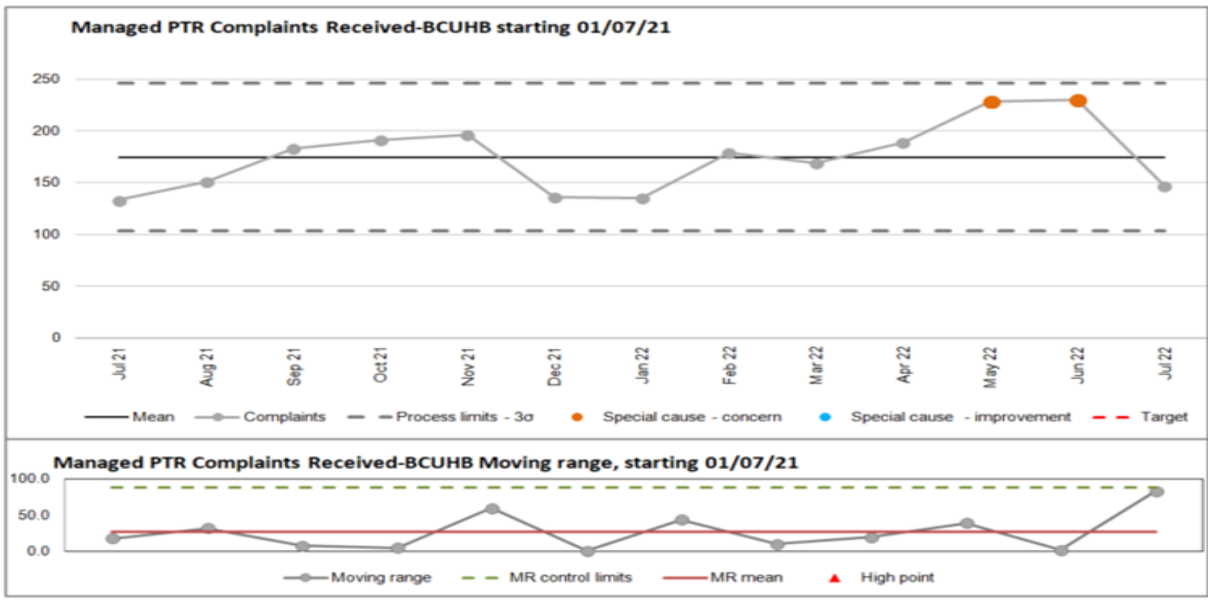
1.5 For ease of reading the charts, variation icons describe the type of variation being exhibited and assurance icons describe whether the system is achieving its target (if applicable).

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

2. COMPLAINTS PERFORMANCE

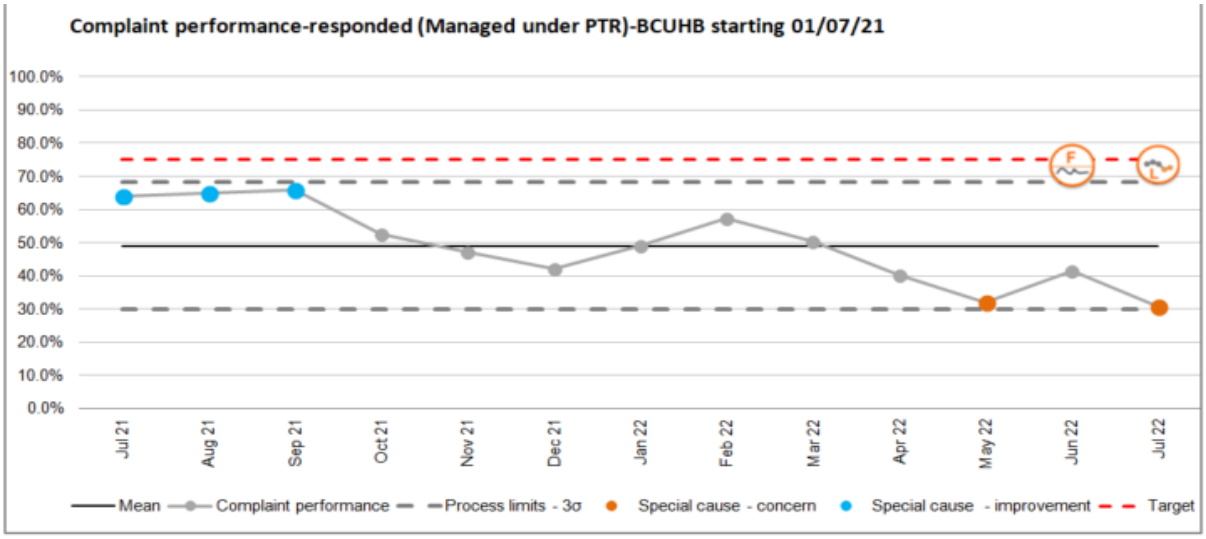
2.1 During the months of April 2022 to July 2022, 1,254 complaints were received by the Health Board. 789 of those were complaints managed under the Putting Things Right Regulations. 461 were initially classified as early resolutions, and 102 of these were later upgraded to being managed under Putting Things Right Regulations (PTR) as services did not manage them to resolution within 2 working days as required.

2.2 The majority of the complaints related to Secondary Care Services, with 63% of the complaints managed under PTR. The themes related to clinical treatment and assessments, poor communication and appointment waiting times. Other re-occurring themes were in relation to patient discharge from hospitals, prescribing and treatments not providing the expected outcomes.



2.3 At the end of July 2022, performance remained below the All Wales target of 75% for complaints closed within 30 working days. On average, the number of complaints closed within the timeframe was 36%. The performance level has continued to drop due to the number of complaints received during the period. In addition, work pressures within services has compromised performance due to capacity and Covid-19 sickness

absence. Integral to the overdue complaints recovery plan, constructive discussions are taking place with Directors of Nursing to establish how services aim to complete all overdue complaints and to manage complaint resolution pro-actively. The Patient and Carer Experience Department are proactively engaging with services to establish which are PALS enquiries and manage timely resolutions. Services are supported to manage early resolutions within 2 working days, preventing further complaints to slip across to grade 1 or 2 complaints managed under PTR.



2.4 The Health Board did not achieve the 75% target for a 30-day response rate. This has led to an increase in the number of overdue complaints during this period. Despite a recovery plan implemented to support the overdue complaints, utilising a targeted approach, and identifying the barriers within the services, contributing to the delayed responses the number of overdue complaints is gradually increasing due to the volume received. A complaints recovery plan is in place **(Appendix: 1);** each service are supported to produce their individual trajectory for overdue complaints.

2.5 Weekly complaints reporting is in place across all services with proactive support for the management of Grade 1 and 2 complaints by the Patient and Carer Experience Department. Scrutiny is consistently applied ensuring complaints managed under PTR as required, whilst seizing opportunities to provide timely resolution where applicable. This in turn will gradually see the number of complaints managed under PTR decreasing appropriately, where there is no allegation of harm.

2.6 Response rates have dropped for Secondary Care West Services, with a response rate of 35% for the months of April 2022 to July 2022 compared to 55% during the months of December 2021 to March 2022. Area West service response rates remain consistent and have improved slightly to 34%. A decline in response rates for Central Secondary Care Service falling to 16%. Key improvement discussions are in place with Quality Improvement Fellow in Ysbyty Glan Clwyd to support complaint resolution by way of workshops with services to address the backlog of overdue complaints. The aim is to roll out this operational model across all sites once it has been finalised. Area Central rates have improved slightly to 49%.The East Secondary Care response times have also dropped to 42%. Mental Health response rates improved to 39% for the months of April and July 2022.

2.7 At the end of July 2022, 436 complaints were overdue.

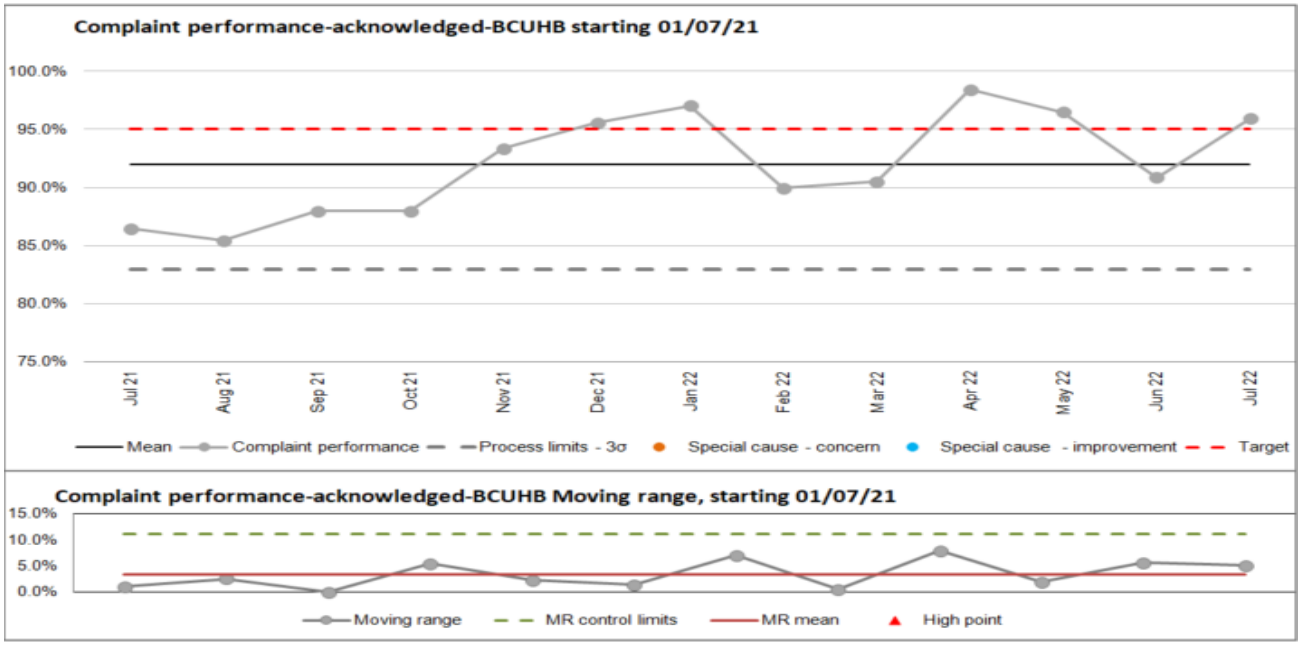
2.8 The number of legacy complaints (prior to the implementation of the new process) continue to fall with three cases remaining open. This has involved significant proactive work across all services and dedicated support to secondary services in particular. Attendance at weekly complaints review meetings, collaborative working with the Public Service Ombudsman Wales (PSOW) lead, attendance to weekly redress clinics and a collaborative approach has supported the closure of legacy responses.

2.9 To overcome the barriers influencing the delayed responses, on-going work from the Corporate Complaints Team has commenced with services to support complaint responses and improve performance to meet Welsh Government Key Performance Indicators. The focus has been to highlight the barriers both the services and complaints team are experiencing, some of those being identifying lead investigators within services to provide resolution, identifying investigating officers with capacity to investigate and explore breach of duty and harm caused within the PTR timescale. The Directors of Nursing have been supportive during meetings with an action tracker in progress to support the management of complaints.

2.10 A plan is in development with the main objective is to improve performance to achieve Welsh Government Complaints Key Performance Indicators, improve patient safety and care ensuring that action plans are implemented and positive changes are made, and to provide support to services with complaint resolution.

- The plan will identify which services require additional support by way of a review of overdue complaints this will be actioned weekly.
- Data extrapolated will be reviewed applying a targeted approach and identifying ‘hot spots’.
- Contacts with site/area leads to manage the recovery plan and provide support.
- Complaints management training will form a key part of the plan.

2.11 During the period of April 2022 to July 2022, 96% of complaints acknowledged within 2 working days, consistent with the previous quarter. Due to the limited capacity within the Corporate Complaints Team during June 2022, the performance level in acknowledging complaints decreased, in addition another contributing factor was the delays in complaints being submitted for triage due to the impact of a lack of resource. The limited capacity was due to vacant posts, secondment opportunities, planned annual leave and sickness within the team.



2.12 As previously highlighted, April to July 2022, 400 early resolutions were recorded and of those 102 were upgraded to complaints managed under PTR.

2.13 Common themes within the early resolutions were consent, confidentiality and communication, as well as access to appointments, admission, transfer and discharge. 89% of the early resolutions were resolved efficiently.

2.14 Emergency Dental Services have been addressing their early resolution cases effectively and efficiently resulting in a reduction of cases triggering to being managed under PTR. This is a significant improvement in dental services managing all dental queries effectively.

3. COMPLAINTS LEARNING

3.1 The new complaints procedure endorses learning as a key element of complaint investigations, facilitated by the application of an investigation report template and guidance for the Investigating Officer to follow.

3.2 When completed the allocated adjudicator approves the investigation report, (the role of adjudicator is at Director of Service level). The adjudicator role also supports the emphasis on learning as a key part of a complaint investigation and assurance and governance arrangements identified actions and improvements completed.

3.3 The Quality Directorate is currently facilitating Civility training sourced externally from Medled, The training will roll out in July and August 2022. Civility plays a fundamental role in team behaviours and how this influences performance in high pressure and risk environments, supporting teams to engage and work positively with each other.

3.4 A thematic analysis is conducted on a weekly basis to identify areas of improvement as part of the weekly situation report, any regular re-occurrences are shared with the senior management within the services to investigate and identify opportunities for

improvement. The three subjects most frequently identified from complaints received during the reporting period were:

- Clinical treatment/assessment (across all services)
- Communication (across all services)
- Appointments (mainly in relation to surgical).

3.5 The Patient and Carer Experience department strive to improve all aspects of communication, the following actions were undertaken in the quarter:

- PALS is working directly with the Medical Examiner Office to ensure families have an opportunity to any issues relating to their loved one's care and treatment answered and to share their experiences.
- Purchase of additional iPads and iPad stands for use in acute and community hospitals to enable patients to conduct virtual calls with their relatives and carers during any restricted visiting.
- Targeted work on hospital wards to explore ways to improve communication between staff and unpaid carers/families.
- Continuing to offer a 'letters to loved ones' service whereby relatives and carers can send a message via phone, letter or email and it will be delivered to the patient.
- Pro-active engagement with the Hergest Mental Health Unit to encourage feedback and identify opportunities for learning and improvement
- Care to Shares on Ward 3 in Ysbyty Glan Clwyd in addition to CCU to promote feedback both negative and positive to drive quality improvement
- The Corporate Complaints Team and Patient Advice and Liaison Service are working in collaboration to provide early resolution to concerns raised in relation to appointment waiting times, there has been a significant improvement particularly in relation to emergency dental appointments.

Case Study

Summary of the Complaint	Action Undertaken	Outcome following investigation
• Long Term Issues in relation to Mother's eyesight • Three different diagnosis and no treatment plan • Delayed appointments • Lack of Communication from Services • Attitude of Staff • Unhappy with Complaint Handling Process	• The Ophthalmology College Tutor has discussed the misdiagnosis with the Registrar involved for learning, this will also form part of the doctors appraisal • Appointments arranged with Emergency Eye Clinic and Consultant • Staff reminded of the Complaints Process and	• An apology • Special Payment issued for £500 for Complaint Handling delays • Legal and Risk Advice Received – if qualifying liability is founded it may exceed the Putting Things Right Limit and legal advice suggested.

	accountability to communicate with patient throughout the process	

4. COVID-19

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

4.2 The Health Board are in continuous contact with the NHS Wales Delivery Unit National Nosocomial Covid Programme (NNCP), working closely with other Health Boards and organisations across Wales. BCUHB was one of the first organisations to adopt a proactive approach to engage with the families of those affected with the nosocomial transmission of Covid-19 to include them as part of the proportionate investigations. The Health Board encourages meeting with families in person to explain, but more so to let them "tell their story". The feedback to date has highlighted the importance of being able to discuss openly in their language of choice i.e. Welsh/English. The Health Board will also encourage staff involved in the patients care to participate in the conversations with families and support staff to understand what patients and families were going through at the time.

4.3 The Health Board will implement a scrutiny panel to review all completed investigations in September 2022. The panel will be responsible for decisions, based on the findings of an investigation and broader triangulation of information, whether:

- The care received by a patient was reasonable at the time, and whether
- Anything further could have been done, in the context of the local operating position during that point of the pandemic, to prevent nosocomial infection of COVID-19.
- If it is identified anything further could have been done, and determine was it reasonable for this not to have been done
- To apply Putting Things Right Regulations.

4.4 The scrutiny panel will report regularly (quarterly as a minimum) to the Executive Team, and through the established organisational Health Board reporting mechanisms:

- Organisational progress of the programme including total number of patient safety incidents of nosocomial Covid-19, investigations completed/underway/yet to start
- The outcome of scrutiny panels about patient outcomes (Death / Severe / Moderate / Low harm / No harm)
- The outcome of scrutiny panels about standard of care in keeping with the purpose and objective of the panel
- Aggregated learning / trends and themes
- Number of cases referred back to investigator for further investigation

- Number of cases referred to Legal and Risk Services
- Case conclusion.

4.5 A Single Point of Contact managed 5 days a week (Monday to Friday) for patients, carers and families affected by health care acquired Covid-19 was established on 20 July 2020 in line with Welsh Government requirements. The contact information is promoted on the BCUHB internal and external internet site.

4.6 The purpose of the dedicated five-day single point of access is to ensure a consistent, dedicated and timely access to support for patients, carers and families affected by nosocomial Covid-19.

4.7 The Work Programme supported by the Delivery Unit (DU) has implemented milestones to be achieved to ensure consistency across Wales. BCUHB are working closely with the DU to ensure that the work programme is aligned to the National Framework for Nosocomial Transmission of Covid-19.

5. OMBUDSMAN

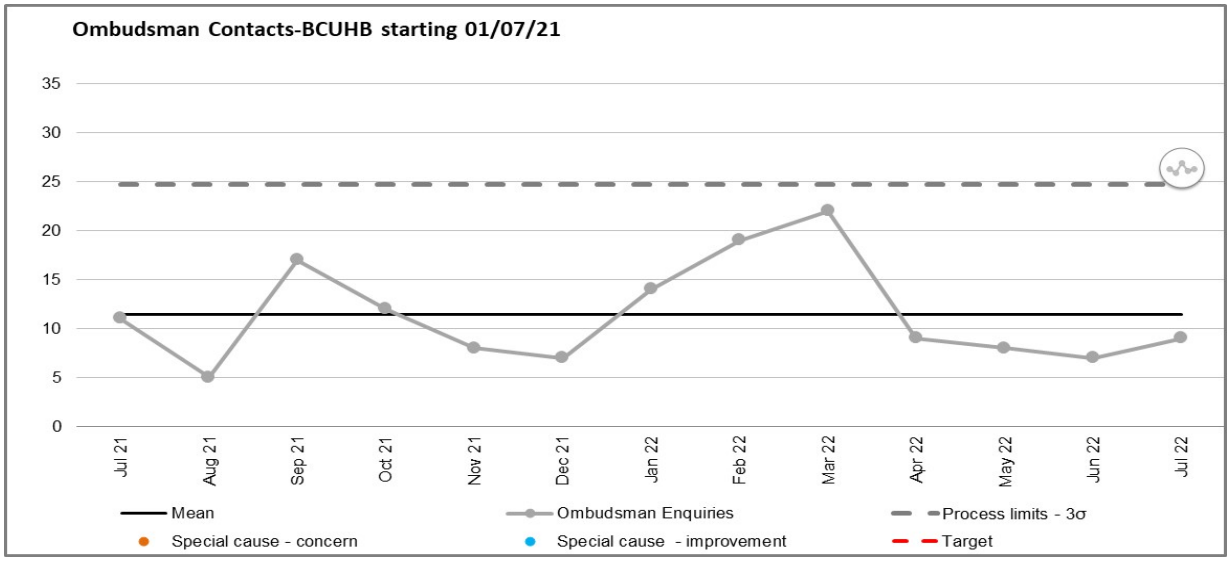
5.1 The Public Services Ombudsman of Wales (PSOW) has legal powers to look into complaints about public services and independent care providers in Wales.

5.2 The Ombudsman's Annual Letter 2021-2022 **(Appendix 2)** was received on 09 August 2022. The Health Board has been requested to continue to engage with the Ombudsman's Complaints Standards work, accessing training for staff, fully implementing the model policy, and providing complaints data. The Health Board will be providing the Ombudsman with a response by 30 September.

5.3 The Health Board has the highest rate of complaints to the Ombudsman of all health boards at 0.30 per 1,000 residents (SBUHB are at 0.28, CTMUHB at 0.25, ABUHB at 0.24, HBUHB at 0.23 and C&VUHB at 0.18). The Health Board has had the highest rate for several years. It is hoped that the new complaints process will reduce this however until the overdue position is addressed, this is unlikely to change as delays in responses will affect patient or carer confidence. It should be noted, the Health Board does actively promote the Ombudsman service and every complaint response includes text in the response letter and a leaflet about the Ombudsman. This "active offer" of giving the Ombudsman details could account for some of the high rate. The position for the Health Board has increased slightly from the previous year (0.26) however of note all Health Boards have seen a noticeable increase (the Health Board increase is the lowest increase). This does reflect the significant increase in complaints seen post-COVID.

5.4 The percentage rate of intervention (i.e. an Ombudsman upheld complaint) is 32%. The average across Health Boards is 30%. By comparison PTHB is 50%, ABUHB is 34%, CTMUHB is 30%, SBUHB and HDUHB is 28% and C&VUHB is 22%. The Health Board intervention rate is slightly lower than the previous year (35%).

5.5 During the period under review, the Ombudsman contacted the Health Board regarding 33 new concerns, compared to 62 in the previous comparable period.



5.6 During the period under review the Health Board has received notification that a further 17 new complaints which will be fully investigated by the Ombudsman, compared to 23 in the prior comparable period.

5.7 The Health Board currently has 84 Ombudsman Investigations ongoing, which is the same as the previous comparable period. Across the Health Board, there are currently 19 cases within the West, 33 cases within Central and 32 cases within East.

5.8 New Public Service Ombudsman for Wales: Ms Michelle Morris was formally nominated by the Senedd on 26 January 2022 as the next new Public Service Ombudsman for Wales, and took office on 01 April 2022. She has recently had her first meeting with BCUHB Chief Executive.

5.9 Audit Wales recently highlighted a discrepancy regarding differences in reporting figures between the Health Board annual report and the Ombudsman annual letter. In previous years, the Health Board was reporting a different set of data to the Ombudsman. In the Putting Things Right (PTR) Annual Report the Health Board was reporting the number of complaints where the Ombudsman had raised enquiries and investigations into, but not cases where the Ombudsman decided not to investigate. Whereas, the Ombudsman was reporting all contacts they had, including cases they decided not to take any action on. The Health Board was therefore reporting a different, and lower, figure in its PTR Annual Reports to that reported by the Ombudsman in their Annual Letter. It is acknowledged the difference in reporting criteria may cause confusion. Going forward, the Health Board will include all Ombudsman cases in its reports and will work with the Ombudsman to ensure the data is aligned across the two reports.

5.10 Monthly virtual calendar dates have been scheduled with the Ombudsman's Head of Complaints Standards to promote partnership working between the Health Board and PSOW.

5.11 Public Interest Reports have been received during the period of April to July 2022.

5.12 **Emerging Themes**

One emerging theme remains the number of cases being returned to the Health Board by the Ombudsman with instruction that they are to be re-investigated under the Putting Things Right Regulations in order to consider Redress. There are currently seven cases under review for Redress. The Investigation Report template has now been amended to ensure breach of duty and qualifying liability are considered where necessary.

Specialties being monitored for increased numbers of complaints being investigated by the Ombudsman are the Continuing Health Care Team who currently have 6 cases, Urology numbers have reduced to 3 cases, Emergency Department numbers have also reduced to 3 cases. An emerging theme in an increased number of cases being investigated relating to HMP Berwyn who have 3 cases and GP Surgeries who now have 7 cases being investigated by the Ombudsman.

6. COMMUNITY HEALTH COUNCIL

6.1 The North Wales Community Health Council (NWCHC) has undertaken a limited number of inspections with a plan to resume inspections. The thematic learning and improvements focus will inform this report in future. The Patient and Carer Experience continue to work closely with the CHC and have regular focused meetings.

6.2 The NWCHC continues to focus on engagement activities and providing advocacy service for complainants.

7. PUTTING THINGS RIGHT - REDRESS

7.1 The NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 state if at any time during the investigation of a complaint or patient safety incident it is considered that a qualifying liability exists or may exist, that would attract financial compensation of £25,000 or less, it must be determined whether or not an offer of redress should be made.

Redress can include one or more of the following:

- A full explanation of what happened;
- An apology;
- An offer to provide care or treatment (where appropriate); and
- A report on action which has been, or will be taken to prevent similar cases arising; and/or
- Financial compensation.

7.2 Between April to July 2022, 17 cases were concluded which involved Redress:

- 2 offers of financial compensation as redress were accepted totalling £6000
- 1 written apology was made

- 3 proceeded to become a clinical negligence claim
- 11 were advised to pursue a clinical negligence claim, as any offer of financial compensation made would exceed the £25,000 limit allowed under Putting Things Right.

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

8. PATIENT AND CARER FEEDBACK FORMATTING

8.1 Patient feedback and listening to the voices of patients, carers and service users, is key to ensure effective service improvement. The Patient and Carer Experience Team continue to collect service user feedback through various in house methods including; paper questionnaires, capturing patient stories, Care 2 Share in depth interviews, enquiries via the Patient Advice Liaison Service (PALS) and analysis of social media.

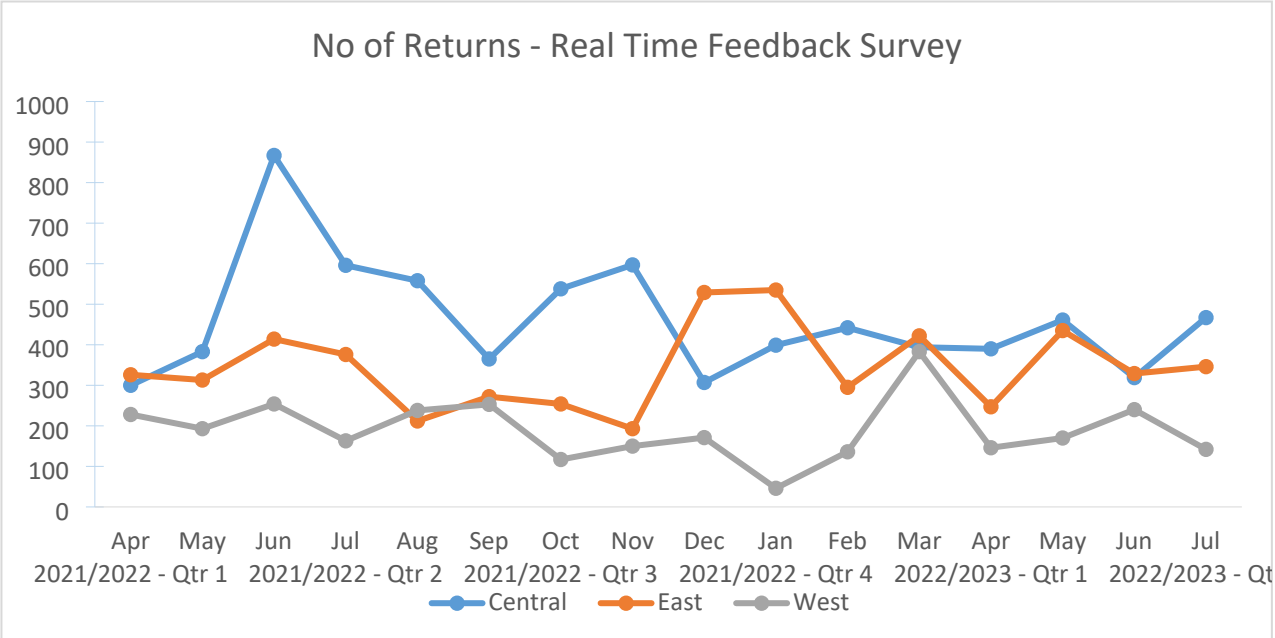
8.2 Please see table below of PALS activity for the reporting period.

PALS Level of Activity					
	Bereavement Support	Care 2 Share	Feedback	PALS Contacts	**Total**
2022/2023					
Apr	3		73	552	629
May			77	556	636
Jun			98	509	609
Jul		10	91	605	707
Total	3	10	339	2,222	2,581

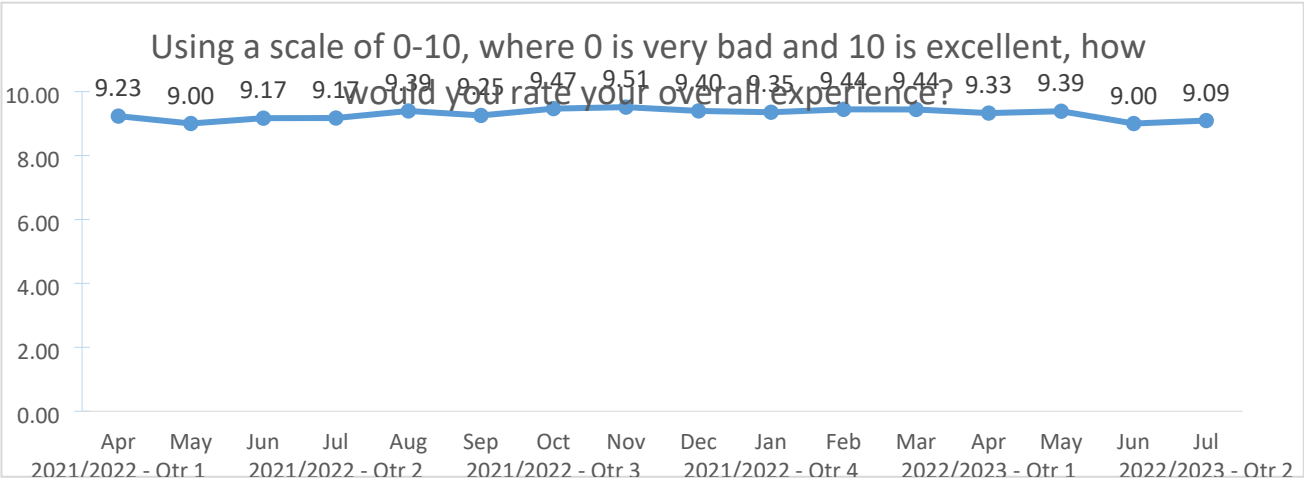
8.3 From April 2021 to July 2022, PALS dealt with 2,222 enquiries. The top three enquiry sub themes included:

- Communication (negative)
- Co-ordination of care (negative)
- Assisting service users (negative).

8.4 There was a slight increase in the number of feedback returns completed in Central and East through the CIVICA real time patient feedback system. The West area recorded a decrease in the number of surveys completed. PALS continue to promote the use of iPads and QR codes to capture patient and carer feedback across services. PALS teams define regions by Central East and West, please see table below the number of returns by regions.



8.5 Overall satisfaction in patients' experience in accessing health board services has decreased slightly from Q3. See table below:



8.6 Positive feedback not only shares good practice, but also raises staff morale and job satisfaction. The Patient and Carer Experience Team continues to select a 'Feel good Friday comment of the Week.' Feedback is shared with the relevant ward/department

along with a certificate and the comment publicised on the Health Board's social media pages. Below is an example of a Feel Good Friday comment received:

> "From the moment I was moved to Ward 8 and I was welcomed by the Sister, the whole team's dedication, teamwork, communication and hard work was apparent from the outset and sustained for the 11 nights I was in their care. I do not underestimate the positive value this had on my wellbeing. I consider it a privilege to have been your patient, I thank you so much." Ysbyty Glan Clwyd

8.7 A Long Covid Partnership Group was established with patients playing an important role in decision making to ensure the voice of the patient is heard throughout the development of the Long Covid service. This approach to co-producing services in partnership with patients has been shortlisted for an NHS Wales award and a finalist for PENNA National Awards for effective partnership working in patient centred care.

8.8 The Patient and Carer Experience Team are working with Mental Health Services (Hergest and Hydref Ward). PALS Officers are attending weekly patient forum meetings at Hydref Ward to capture any enquiries or feedback to help inform service improvement.

8.9 Support is being provided to the Vascular Service and Urology Service by providing staff with a package of support to help increase patient and carer feedback. Recent Care 2 Share discovery interviews with Vascular patients on Ward 3 at Ysbyty Glan Clwyd identified staff were very caring and compassionate. Patients felt the time taken by staff to respond to the call bell need to be improved. A Urology patient representative has been involved in looking at opportunities to increase patient feedback through a dedicated Urology campaign targeting patients accessing the Urology Service. Suggestions included improving the Urology Service webpage adding support information and looking at developing materials to give out at outpatient appointments.

8.10 The Patient and Carer Experience Team have been supporting Ysbyty Glan Clwyd Emergency Department. Over a three week period there was a daily presence from PALS to encourage patient and carer feedback and support with any early resolution enquiries. PALS undertook Care2Share discovery interviews and observational slots in the waiting and treatment areas. As a result of PALS feedback direct service improvements were made in relation to communication of approximate waiting times on visual board in the waiting area and reduction of negative PALS enquiries over three month period.

9. PATIENT & CARER STORIES

9.1 Stories told by individuals from their own perspective regarding a health care setting, or the care they have received, has been identified as a powerful tool to understand their

lived experience. In May, PALS captured their first young person patient story. In total PALS Officers captured 14 patient/carer stories around the following themes:

- The patient would like to see more flexibility in dialysis shifts available but this was not possible due to the absence of the 6 day transport services from WAST.
  Learning – The patient story was shared with WAST. The commissioning of a 6-day service for renal transport in BCUHB was approved in July.
- Childrens Outpatient Department in Ysbyty Glan Clwyd – young person shares how staff have helped him overcome his fear of having his bloods taken.
  Learning – This positive story was shared back to the Outpatient service and will be used for future staff training.
- Mental Health (Nant Y Glyn) – Impact of long waiting times, and lack of support whilst waiting to be allocated a Care Co-ordinator.
  Learning – Learning fed directly back to the service and at the Mental Health Patient and Carer Experience meeting.
- Patient's dementia diagnosis was not taken into account when accessing an Emergency Department – staff lack of awareness of the butterfly scheme.
- **Learning** – The Patient and Carer Experience Team are working with the Dementia Specialist Nursing Team to explore re-launching the butterfly scheme across the Health Board.
- Patient diagnosed with Prostate Cancer whilst living in England. Having relocated to North Wales, he transferred his care to BCUHB. Patient experienced delays in being reviewed and he no longer had access to a dedicated Macmillan Nurse as in England.
  Learning – The impact of waiting times on transfer cases. Wales Macmillan Nurse service needed to be promoted more widely.

10. PATIENT EXPERIENCE BEREAVEMENT AND LIAISON SUPPORT

10.1 PALS are working directly with the Medical Examiner Office to ensure families have an opportunity to have any unanswered questions answered around the loss of a loved one and to share their experiences

10.2 PALS continue to offer a bereavement and liaison telephone service with the aim to listen to families and offer advice and support at such a difficult time. In this reporting period, the Patient and Carer Experience Service responded to three PALS Bereavement related enquiries that came through the PALS Bereavement support telephone line.

11. LETTERS TO LOVED ONES

11.1 Letters to Loved Ones was an initiative developed by the Patient and Carer Experience Team as a response of the restricted visiting measure to help maintain communication between loved ones and patient. From April to July 2022, the Patient and Carer Experience Team received 19 Letters to Loved Ones requests for inpatients from family and friends. Below is the breakdown of requests per locality:

- Wrexham Maelor Hospital - 1
- Ysbyty Gwynedd - 2
- Ysbyty Glan Clwyd - 16

11.2 Since visiting restricting have eased there has been a reduction in requests for letters to loved ones as families are now able to see their relatives and loved ones.

12. IMPROVING CARER EXPERIENCE

12.1 Supporting unpaid carers is a key priority for the Patient and Carer Experience Department. Key highlights for this reporting period include:

- Patients now have weekly access to unpaid carer support onsite in the PALS hubs at Ysbyty Gwynedd and Wrexham Maelor Hospital from NEWCIS and Carers Outreach.
- In June, the Carer Experience Manager led on a one-week national campaign to raise awareness of unpaid carers working in partnership with NEWCIS and Carers Outreach focused around the theme ‘did you know’...
- Continued contact with Carers Trust Wales to look at piloting the new Triangle of Care model within the Health Board.
- Continuing to represent BCUHB at external partnership meetings with local authorities and third sector organisations including sharing information and learning from carer experience stories.
- Capturing of two carer stories taken, sharing lived experience of being an unpaid carer of a patient.
- In partnership with Carers Trust, Health Boards and stakeholders working towards producing a guide for staff to support carers through hospital discharge.
- Supporting unpaid carer complex PALS enquiries.

13. PATIENT & CARER CHAMPIONS

13.1 A patient and carer champion is someone who is passionate about patient care. The patient champion role allows members of staff to personally support the patient and carer experience team to drive change and understand patient feedback.

The role of a patient and carer champion is to:

- Liaise with the patient experience team
- Support and actively promote the collection of patient experience feedback
- Signpost patients, service users and their carers to supportive services
- Ensure that ward/area patient experience information is up to date
- Ensure that the needs of carers are identified and supported
- Escalate any patient experience problems to both the service and the PE team
- Participate in monthly updates

Patient and carer champions work closely with the Patient and Carer Experience Department by sharing information and engaging in patient feedback collection.

Patient and carer champions are a point of contact to improve engagement between the team and clinical services. By asking, monitoring and acting towards patient feedback, we are able to make improvements for our service users to gain a greater experience of care

13.2 Staff who are Patient and Carer Champions continue to meet as a group virtually on a monthly basis. In this reporting period there have been 3 guest speakers attending these meetings to deliver signposting and awareness training representing the following organisations:

- Connects North Wales. Age Connects is committed to services and activities that promote healthy ageing, proactively helping older people to tackling loneliness and isolation.
- I CAN is a programme aimed at offering support to improve overall mental wellbeing through a range of services across North Wales.
- Age Cymru Dementia Advocacy Project. The project provides advocacy for older people with a diagnosis of dementia or older people going through the process of diagnosis or at the stage of pre-assessment with memory concerns.

14. ACCESSIBLE HEALTH CARE

14.1 In collaboration with BCUHB managers and staff, the content of the Sensory Loss Toolkit and other supporting information is now available online through SharePoint for staff to access. As part of the Sensory Loss Toolkit review, a sensory loss mental health section has been included providing signposting to specialist support services to help mental health patients who experience sensory loss.

14.2 The Patient and Carer Experience Department have now taken over the management of Welsh Interpretation and Translation Service (WITS) including the digital roll out of 24-hour access to interpreters. This is a key improvement for timely interpretation availability, reducing delayed appointments due to face-to-face interpreters being required to travel long distances. Face-to-face interpretation remains the gold standard; however, patients and carers will now have options. A shortage of Ukrainian interpreters has been highlighted; BCUHB and WITS are working collaboratively to support the need.

15. CONCLUSION

15.1 This report provides the Quality, Safety and Experience Committee with information and analysis on patient and carer experience. It highlights a range of positive areas of practice as well as some challenges such as complaints performance.

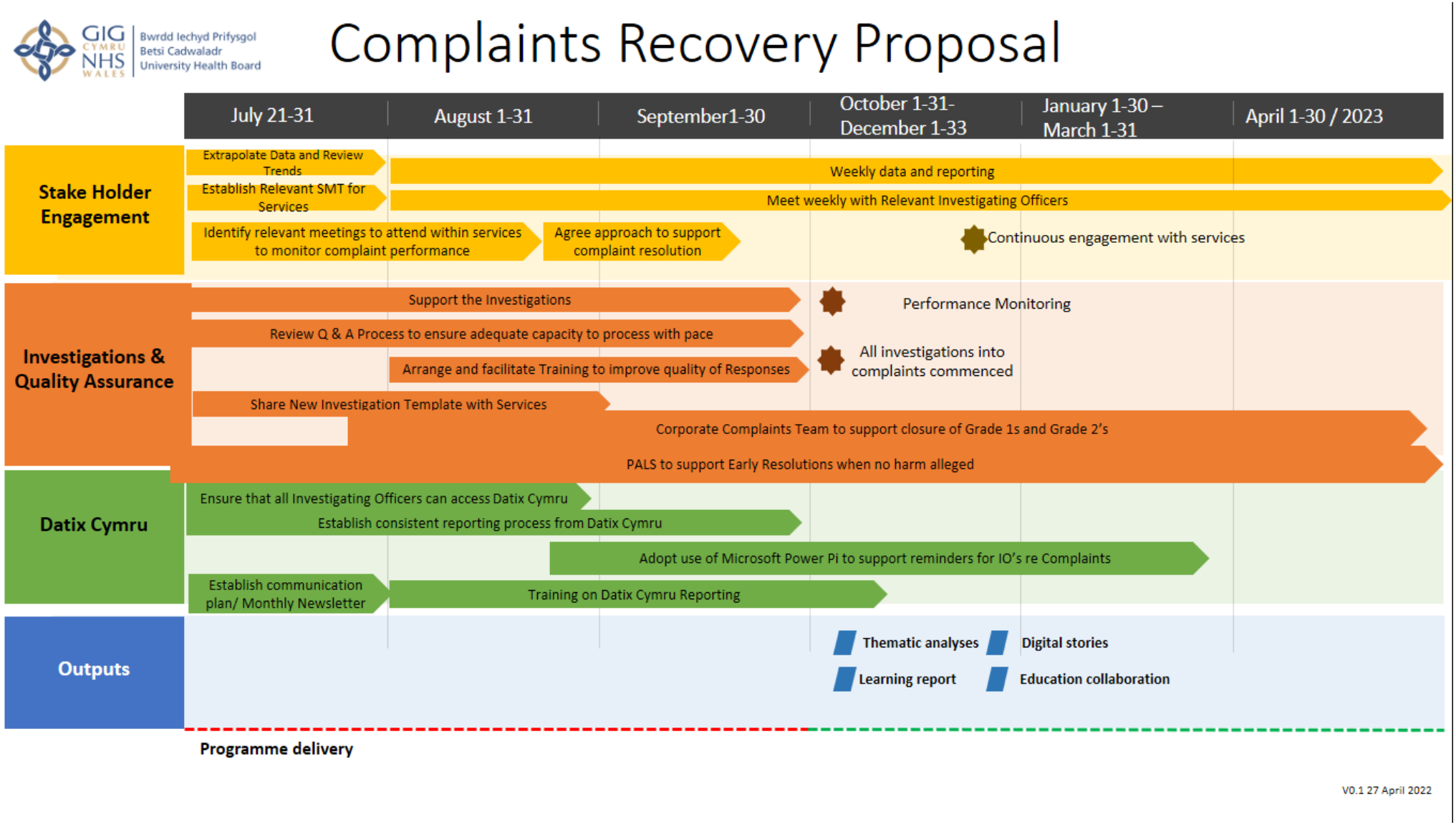
15.2 This report highlights that there is limited feedback from some service areas, which is symptomatic of a lack of capacity.

15.3 The complaints performance to provide a response within the 30 working day period as per the Putting Things Right Guidance remains well under the target of 75%, this aligns to the lack of engagement and pressures within the services. The common themes are a lack of communication with patient, carers and families, access to appointments and patient discharge. These are commensurate with feedback from other sources, for example, Patient Advice and Liaison Service and activity data.

15.4 Services need to become increasingly pro-active in complaints management supported by the Complaints Team and their service managers. A targeted plan, developed in collaboration with the Directors of Nursing, is under development and will be implemented over the remainder of the year.

15.5 The QSE Committee is asked to note the report.

Appendix 1


GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
Complaints Recovery Proposal
July 21-31
August 1-31
September1-30
October 1-31- December 1-33
January 1-30 – March 1-31
April 1-30 / 2023
Stake Holder Engagement
Extrapolate Data and Review Trends
Establish Relevant SMT for Services
Weekly data and reporting
Meet weekly with Relevant Investigating Officers
Identify relevant meetings to attend within services to monitor complaint performance
Agree approach to support complaint resolution
Continuous engagement with services
Investigations & Quality Assurance
Support the Investigations
Performance Monitoring
Review Q & A Process to ensure adequate capacity to process with pace
Arrange and facilitate Training to improve quality of Responses
All investigations into complaints commenced
Share New Investigation Template with Services
Corporate Complaints Team to support closure of Grade 1s and Grade 2's
PALS to support Early Resolutions when no harm alleged
Datix Cymru
Ensure that all Investigating Officers can access Datix Cymru
Establish consistent reporting process from Datix Cymru
Adopt use of Microsoft Power Pi to support reminders for IO's re Complaints
Establish communication plan/ Monthly Newsletter
Training on Datix Cymru Reporting
Outputs
Thematic analyses
Digital stories
Learning report
Education collaboration
Programme delivery
V0.1 27 April 2022

APPENDIX 2

Ombwdsmon Ombudsman
OMBWDSMON GWASANAETHAU CYHOEDDUS CYMRU
PUBLIC SERVICES OMBUDSMAN FOR WALES

Ask for: Communications

01656 641150

communications@ombudsman.wales

Date: August 2022

Mark Polin

Betsi Cadwaladr University Health Board

By Email only: mark.polin@wales.nhs.uk

Annual Letter 2021/22

Dear Mark

I am pleased to provide you with the Annual letter (2021/22) for Betsi Cadwaladr University Health Board which deals with complaints relating to maladministration and service failure and the actions being taken to improve public services

This is my first annual letter since taking up the role of Public Services

Ombudsman in April 2022, and I appreciate that the effects of the pandemic are still being felt by all public bodies in Wales. Our office has not been immune from this, with records numbers of cases being referred to us over the last two years. The strong working relationships between my Office and Health Boards continues to deliver improvements in how we are dealing with complaints and ensuring that, when things go wrong, we are learning from that and building stronger public services.

Complaints relating to Maladministration & Service Failure

Last year the number of complaints referred to us regarding health boards increased by 30% (compared to 20/21 figures) and are now well above prepandemic levels. It is likely that complaints to my office, and public services in general, were suppressed during the pandemic, and we are now starting to see the expected 'rebound' effect.

During this period, we intervened in (upheld, settled or resolved at an early stage) a similar proportion of complaints about public bodies, 18%, when compared with recent years. Intervention rates (where we have investigated complaints) for health boards also remained at a similar level – 30% compared to 33% in recent years.

We will be liaising closely with Health Boards, Welsh Government and the Community Health Councils to monitor likely caseloads over the coming year, including in relation to any cases of Nosocomial transmission of Covid which may reach my office after the Board's local investigations under the national framework have been completed.

Supporting improvement of public services Improvement Work

The Public Services Ombudsman (Wales) Act 2019 formalised our work with public bodies to improve complaints handling and learning from complaints. This work has now been consolidated within our Improvement Team who are engaging with a wide range of organisations to support better complaints handling in public bodies.

Proactive Powers

In addition to managing record levels of complaints, we also continued our work using our proactive powers in the Public Services Ombudsman (Wales) Act 2019. Specifically undertaking our first Own Initiative Investigation and continuing our work on the Complaints Standards Authority.

October 2021 saw the publication of the first own initiative investigation in Wales: Homelessness Reviewed. The investigation featured three Local Authorities and sought to scrutinise the way Homelessness assessments were conducted. The report made specific recommendations to the investigated authorities, as well as suggestions to all other Local Authorities in Wales and Welsh Government. Some of these recommendations will bring about immediate change – updating factsheets and letter and assessment templates to ensure that key equality and human rights considerations are routinely embedded into processes for example – all the recommendations were designed to bring about tangible change to people using homelessness services in Wales.

The Complaints Standards Authority (CSA) continued its work with public bodies in Wales last year. The model complaints policy has already been adopted by local authorities and health boards in Wales, we have now extended this to an initial tranche of Housing Associations and Natural Resources Wales. The aim being to implement this work across the Welsh public sector.

In addition to this, the CSA published information on complaints handled by local authorities for the first time – a key achievement for this work. The CSA receives similar data from Health Boards on a quarterly basis in line with Welsh Government reporting responsibilities, and will look to publish this data for the first time later in 2022.

The CSA has now implemented a model complaints policy with nearly 50 public bodies, and delivered 140 training sessions, completely free of charge, during the last financial year. The feedback has been excellent, and the training has been very popular - so I would encourage Betsi Cadwaladr University Health Board to engage as fully as possible.

Complaints made to the Ombudsman

A summary of the complaints of maladministration/service failure received relating to your Health Board is attached.

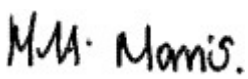
Finally, can I thank you and your officials for the positive way that health boards have engaged with my Office to enable us to deliver these achievements during what has been a challenging year for everyone. I very much look forward to continuing this work and collaboration to ensure we further improve public services across Wales.

Further to this letter can I ask that your Health Board takes the following actions:

- Present my Annual Letter to the Board and share any feedback from the with my office.
- Continue to engage with our Complaints Standards work, accessing training for your staff, fully implementing the model policy, and providing complaints data.
- Inform me of the outcome of the Board's considerations and proposed actions on the above matters by 30 September.

This correspondence is copied to the Chief Executive of your Health Board and to your Contact Officer. Finally, a copy of all Annual Letters will be published on my website.

Yours sincerely,



Michelle Morris

Public Services Ombudsman

Cc. Jo Whitehead, Chief Executive, Betsi Cadwaladr University Health Board

By Email only: jo.whitehead@wales.nhs.uk

Factsheet

Appendix A - Complaints made to PSOW

Health Board	Complaints Received	Received per 1000 residents
Aneurin Bevan University Health Board	142	0.24
Betsi Cadwaladr University Health Board	213	0.30
Cardiff and Vale University Health Board	89	0.18
Cwm Taf Morgannwg University Health Board	113	0.25
Hywel Dda University Health Board	88	0.23
Powys Teaching Health Board	10	0.08
Swansea Bay University Health Board	110	0.28
Total	765	0.24

Appendix B – Complaints made to PSOW by subject

Betsi Cadwaladr University Health Board	Complaints Received	% share
Ambulance Services	0	0%
Appointments/admissions/discharge and transfer procedures	8	4%
Clinical treatment in hospital	104	49%
Clinical treatment outside hospital	23	11%
Complaints Handling	27	13%
Confidentiality	1	0%
Continuing care	8	4%
COVID19	7	3%
De-registration	0	0%
Disclosure of personal information / data loss	0	0%
Funding	0	0%
Medical records/standards of record-keeping	0	0%
Medication> Prescription dispensing	1	0%
Mental Health	12	6%
NHS Independent Provider	0	0%
Non-medical services	2	1%
Other	10	5%
Out Of Hours	0	0%
Parking (including enforcement and bailiffs)	0	0%
Patient list issues	5	2%
Poor/No communication or failure to provide information	0	0%
Prisoner Care	1	0%
Referral to Treatment Time	2	1%
Rudeness/inconsiderate behaviour/staff attitude	2	1%
	213	

Appendix C – Complaints closed by PSOW - Outcomes

(* denotes intervention)

Local Health Board/NHS Trust	Out of Jurisdiction	Premature	Other cases closed after initial consideration	Early Resolution/voluntary settlement*	Discontinued	Other Reports- Not Upheld	Other Reports Upheld*	Public Interest Report*	Total
Betsi Cadwaladr University Health Board	34	29	61	29	0	8	30	2	193
% share	18%	15%	32%	15%	0%	4%	16%	1%	

Appendix D - Cases with PSOW Intervention

	No. of Interventions	No. of Closures	% Of Interventions
Aneurin Bevan University Health Board	42	125	34%
Betsi Cadwaladr University Health Board	61	193	32%
Cardiff and Vale University Health Board	18	81	22%
Cwm Taf Morgannwg University Health Board	30	99	30%
Hywel Dda University Health Board	23	82	28%
Powys Teaching Health Board	3	6	50%
Swansea Bay University Health Board	29	105	28%
Total	**206**	**691**	30%

Information Sheet

Appendix A shows the number of complaints received by PSOW for all Health Boards in 2021/2022. These complaints are contextualised by the number of people each health board reportedly serves.

Appendix B shows the categorisation of each complaint received, and what proportion of received complaints represents for the Health Board.

Appendix C shows outcomes of the complaints which PSOW closed for the Health Board in 2021/2022. This table shows both the volume, and the proportion that each outcome represents for the Health Board.

Appendix D shows Intervention Rates for all Health Boards in 2021/2022. An intervention is categorised by either an upheld complaint (either public interest or non-public interest), an early resolution, or a voluntary settlement.

Report title:	Quality Achievements			
Report to:	QSE Committee			
Date of Meeting:	Tuesday, 06 September 2022			
Executive Summary:	The purpose of this report is to provide the Committee with some of the Health Board's recent awards, achievements and recognitions in relation to Quality and Safety.			
Recommendations:	The committee is asked to receive this report.			
Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery			
Report Author:	Matthew Joyes, Associate Director of Quality Erika Dennis, Quality Lead Manager Amanda Blaynee-Roberts, Quality Business Support Manager			
Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☐	
Assurance level:	Significant ☒ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
This paper highlights some of the recent quality awards, achievements and recognitions				
Link to Strategic Objective(s):	Quality			
Regulatory and legal implications	N/A			
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	N/A			
Financial implications as a result of implementing the recommendations	N/A			
Workforce implications as a result of implementing the recommendations	N/A			
Feedback, response, and follow up summary following consultation	N/A			
Links to BAF risks: (or links to the Corporate Risk Register)	N/A			
Reason for submission of report to confidential board (where relevant)	N/A			
Next Steps: N/A				
List of Appendices: Quality Achievements paper				

Betsi Cadwaladr University Health Board
Quality Achievements

New Stroke Rehab Unit opens to patients at Ysbyty Eryri in Caernarfon

A new rehabilitation unit to help boost the recovery of stroke patients has opened at Ysbyty Eryri in Caernarfon.

This is the first of three new rehabilitation centres across North Wales for patients who no longer need specialist stroke treatment at an acute hospital, but still require stroke rehabilitation that cannot be delivered at home.

The unit is attached to a dedicated 12-bedded inpatient Stroke Ward ran by the multidisciplinary team who are involved in their rehabilitation.

Dr Salah Elghenzai, Consultant Physician and Stroke Specialist at Ysbyty Gwynedd, said: “Many hospital in patients who are recovering from a stroke can often be inactive during parts of their day, which puts their recovery at risk, as well as increasing the risk of other conditions such as frailty.

“The new unit at Ysbyty Eryri will help to minimise these risks and the patients will benefit from active rehabilitation and stroke care, which will mean they are more likely to survive the stroke and return home to live an independent life.”

Seren Betsi Star Award - Stephanie Rees

A Junior Doctor who has given her own time to help school children in North Wales begin their medical studies has been recognised with a surprise award. Stephanie Rees, a clinical fellow in the Intensive Care Unit of Ysbyty Glan Clwyd, has received a Seren Betsi Star award for her work on the Widening Access to Medicine scheme.

Consultant Anaesthetist Dr John Glen presented the award during a session at the lecture theatre where Stephanie, unaware of the impending surprise, was attending with her peers. Speaking after receiving her award Stephanie said: "It was a complete surprise to win the award. Support like this is very important for prospective medical students in North Wales. Dr Glen said: “The scheme has been a great success. Every student who has completed the programme has received an offer to study medicine at university. This is a remarkable achievement.

The positive impact of Stephanie’s efforts on young people who have ambitions of a medical or dentistry career has been recognised by Welsh Government. The scheme has been extended to Ysbyty Gwynedd and Wrexham Maelor Hospital, where Stephanie has trained staff there to organise and run their own programmes using the materials and methods she devised.

North Wales Artificial Limb Centre Celebrates Big Anniversary

Thirty-one years after Princess Diana officially opened the Artificial Limb and Appliance Centre (ALAC) at Wrexham Maelor Hospital, staff have been looking back at her visit.The honey-coloured building on Croesnewydd Road, across from the main Wrexham Maelor Hospital, was opened on July 30th 1991 by the Princess of Wales. Staff are celebrating the 31st anniversary this year, as COVID-19 restrictions halted celebrations for its 30th in 2021.

Stephen Jones, Head of Posture & Mobility, said: “The service has evolved and developed since originally being opened and we strive to improve upon the service since it was opened by Princess Diana. The use of the building and the services delivered has changed, and it was a privilege to be able to use the building to facilitate the COVID vaccine programme. The ALAC in Wrexham is one of three centres based in Wales and is provided by a unique collaboration between three Health Boards and is commissioned via Welsh Health Specialised Services Committee (WHSSC).

Project SEARCH Graduates Celebrate Success

A group of Project SEARCH interns became proud graduates this month, receiving their certificates at a ceremony in front of their families. Project SEARCH is a 12-month internship for young education leavers with learning disabilities or autism.

Project SEARCH’s primary objective is to secure competitive employment. Nationally, the unemployment rate for adults with disabilities/autism is approximately 90 per cent, Project SEARCH supports the development of skills and behaviours that support these young adults in to meaningful paid employment.

The ceremony was held at Grŵp Llandrillo Menai College’s Llangefni campus with the certificates presented to the interns by the Chief Executive of Agoriad Cyf Arthur Beechy and Assistant Principal for Grŵp Llandrillo Menai Bryn Hughes Parry. Mr Hughes Parry said: “This unique project is an excellent example of partnership working in improving the future of our young people.”

Ambitious Public Sector Partnership to Provide Nursing Care in Gwynedd

Gwynedd Council has approved a proposal to develop an ambitious partnership with Betsi Cadwaladr University Health Board to provide nursing home placements within the county.

Gwynedd Council’s Cabinet Member with responsibility for the Adults, Health and Wellbeing Department, Councillor Dilwyn Morgan said: “I am delighted that the Council Cabinet has approved these radical recommendations to form a partnership with our Health Board colleagues to consider our role as providers of nursing care as part of a wider market. Jo Whitehead, Chief Executive at Betsi Cadwaladr University Health Board, said: “We are pleased to be working with Gwynedd Council on this proposal to provide nursing home provision in the county. “Detailed planning will be required for this initiative and trying to recruit staff is very challenging for the majority of care providers in Gwynedd. “We are in the process of discussing options with local universities who provide nursing courses as well as looking at creating opportunities for our nursing staff already working in the Health Board.”

Pioneering Hepatitis C Project helps more vulnerable people get tested and treated

An award-winning outreach project which has helped dozens of the most vulnerable people in North Wales get treated for Hepatitis C will be rolled out in Bangor later this year.

The team behind the health board's Rapid Test and Treat programme say their approach has already helped marginalised communities in Wrexham and Rhyl get faster access to potentially life-saving medicines. Their pioneering new approach – the first of its kind in Wales – has made getting tested easier and faster for homeless and other disadvantaged people.

The project brings together members of our pharmacy, point of care testing, gastroenterology, hepatology, substance misuse and harm reduction teams. It is expected to deliver significant savings, with the cost of providing early treatment for Hepatitis C significantly lower than treating longer-term complications.

Patients set to be seen and treated faster thanks to new funding

Patients with stomach and intestinal problems will be seen quicker following the launch of a Gastroenterology clinic in Flintshire and Wrexham. Led by dietitians, the clinic will see, diagnose and treat non-urgent patients and is expected to help reduce overall waiting times.

The project, funded for one year by the Bevan Commission's Planned Care Innovation Programme, is called First Contact Advanced Clinical Practitioner (ACP) Dietitian Led Gastroenterology Clinic, which means that non-urgent patients with gut issues can be directly referred to an ACP Gastroenterology Dietitian for an initial assessment, diagnostics and management.

Jeanette Starkey, Gastroenterology Dietitian, Advanced Clinical Practitioner and Clinical Lead, said: "We have reviewed the skill mix within the gastroenterology department and, based on previous work, have identified that by utilizing the skills of an advanced clinical practitioner gastroenterology dietitian, we can significantly improve our outpatient services.

"This is a more streamlined, safe and effective pathway for patients with non-urgent gut issues."

Award Winning Jackie Honoured for Contribution to Innovative Treatment

A health board staff member has been honoured by a charity enterprise for her role in developing innovative services, which help prepare cancer patients for treatment. Jackie Pottle, Macmillan allied health professional therapy cancer lead, based at Glan Clwyd Hospital, received her Emerging Leader award at a gala presentation event in Cardiff last week.

She has also been instrumental in developing support for cancer related fatigue, for people with all types of the disease. Jackie, who works at Betsi Cadwaladr University Health Board, was delighted allied health professionals were recognised through her win.

She said: "I was very surprised to be shortlisted for the award, let alone win. It is great the work of allied health professionals has been showcased through these awards. The accolade was part of the Moondance Cancer Initiative, which celebrates work to combat the cancer within the Welsh NHS. Commenting on the Moondance Cancer Awards, Dr Megan

Mathias, Chief Executive of Moondance Cancer Initiative, said: “The awards were created to both celebrate and thank the people who have dedicated their time to improving and pioneering detection, diagnosis and treatment pathways across cancer services in Wales.

Teitl adroddiad: ***Report title:***	Health & Safety Executive – Notice of Contravention
Adrodd i: ***Report to:***	Quality, Safety & Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022
Crynodeb Gweithredol: ***Executive Summary:***	This report sets out the letter of contravention issued by the Health and Safety Executive on 9th May and the response submitted by the Health Board.
Argymhellion: ***Recommendations:***	The Committee is asked to – i. **NOTE** the detailed breaches and response issued on 11th August 2022 ii. **NOTE** the measures to provide additional oversight of the work underway to address the breaches identified by the Health & Safety Executive
Arweinydd Gweithredol: ***Executive Lead:***	Sue Green, Executive Director Workforce & Organisational Development
Awdur yr Adroddiad: ***Report Author:***	Sue Green - Executive Director of Workforce and Organisation Development

Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒

Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☒ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*

Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn:

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

A draft Improvement plan had been developed by the service in response to the external Independant Serious Incident Review (as reported to this Committee in January 2022. In addition, a specific plan to address the breaches identified had developed by the service (as reported to the last meeting of the Committee). There are elements of these plans that can be evidenced (hence the partial assurance) i.e. Policy development, Bed removal and ceasing of mixed cohorting of patients. However, there is a need for more targetted work within the service, overseen by the Executive Director of Public Health and Chief Executive (given the seriousness of the situation). Second line assurance will continue to be provided by the Health and Safety team advised by Legal and Risk.	
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Identified breach of Section 3 - Health and Safety at Work etc. Act 1974 (as amended) enforceable under criminal law.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	N/A
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	N/A
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	BAF/CCR risk reference BAF21-13- re regulatory action as a result of breach of Health and Safety legislation CRR Manual Handling – CRR21-16 CRR/risk Register risk reference 3929 (MHLD 097)– re harm from ligature
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	1. Fee for Intervention - Health and Safety and Nuclear (Fees) Regulations 2021, Regulations 23 and 24 - £13,670.30 to date
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no workforce implications as a direct result of this report
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol)	See Above

Links to BAF risks: *(or links to the Corporate Risk Register)*	
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Next Steps: i. Finalisation of the Focussed Improvement Plan by the Service ii. Confirmation of the arrangements for oversight of delivery of this plan iii. Confirmation of arrangements for Institution of Occupational Safety & Health (IOSH) Leading Safely training	
List of Appendices N/A	

1. Introduction

The purpose of this report is to provide an update in respect of the Notice of Contravention issued by the Health and Safety Executive (HSE) in relation to the Mental Health and Learning Disabilities Service ("the Service") following the tragic death of a patient in Hergest Unit on 20th April 2021.

2. Health & Safety Executive (HSE) Management and 2nd Level Assurance

2.1 Role of the Health, Safety and Security Team

The primary purpose of the Corporate Health, Safety and Security team is to ensure the Health Board:

- Is clear on the organisations compliance with Health and Safety Legislation and relevant Statutory Instruments owned and enforced by the Health and Safety Executive;
- Is clear on the risks identified as a result of full or partial non-compliance with the above;
- Is advised on the systems of control required and in place;
- Has accessible enabling support and expertise to achieve compliance
- Has a plan in place to ensure continued improvement in both compliance and best practice
- Has a consistent relationship management arrangement in place with the Health and Safety Executive

In pursuance of this purpose there are occasions when the Health, Safety and Security team must apply an objective approach in the identification of the risks to the Health Board of an identified breach and the response or remedial action required, independent of the service where the breach has occurred or been identified (i.e. a separation of duties between assurance and delivery).

2.2 Legal and Risk

Following receipt of the Notice of Contravention, the Health, Safety and Security team commissioned advice from the NWSSP Legal and Risk Service. Given the complexity of this case, and on the advice of Legal and Risk colleagues, Counsel was instructed to review the information used by the HSE to inform the decision to issue the Notice of Contravention, together with information provided by the Service in relation to actions taken following the incident, Serious Incident Review and receipt of the Notice.

The advice received has supported the assurance rating described earlier in this report together with the response to the HSE. In addition, it has informed the recommendations made by the Health, Safety and Security Team in respect of the actions required.

As this advice is subject to legal privilege it is provided under a separate confidential item.

3. Breaches identified in the Notice of Contravention and response issued

Safety of In-Patients during Admission**.**

Section 3 of the Health and Safety at Work etc. Act 1974 (as amended) requires the Health Board to conduct its undertaking in such a way as to ensure, so far as is reasonably practicable, that persons other than themselves or their employees (such as Patient X), are not exposed to risks to their health or safety.

The *HSE* identified the following three failings which it considers resulted in the breach of the above legislation:

3.1 Risk Assessment and Care and Treatment Plan

"In the MHLD Acute Care Operating Framework document (MHLD 0001), it specifies that an assessment of risk regarding an in-patient should be conducted, utilising the MHM clinical documents provided in the framework. This assessment should be completed within the first 12 hours.

The risk assessment document relating to Patient X was dated 5th September 2020. Whilst someone (unknown) wrote in two handwritten revisions to the risk assessment on the 13/4/2021, the whole risk assessment process should have been updated, to assess the condition that Patient X was presenting on this admission.
It was clear from the admission, that Patient X had been deeply disturbed and that her mindset had been to end her own life. This information had not been captured on the initial risk assessment, nor was it properly reflected in the short 13th April revision.

The risk assessment should have been updated once changes to the inpatient care were modified, in light of increased risk of suicide. Therefore, there should have been a revision to the risk assessment once Patient X had on the 17th April 2021, expressed suicidal thoughts to nursing staff and other patients.

Similarly, the Care and Treatment Plan for Patient X, should according to your framework document, have been initiated within 12 hours of admission. This was not completed until the evening of the 15th April 2021.

This plan had indicated that any increase in thoughts of deliberate self-harm, or increase in suicidal thoughts, would indicate that Patient X may require additional support from staff. The treatment plan had not detailed the clear known evidence, that Patient X was expressing motivation towards committing suicide, nor had it indicated actions necessary to reduce this likelihood, such as removal of potential ligatures and placement in an anti-ligature bed.

Had these documents have been completed, the real risk of Patient X harming herself may have been fully appreciated. This may have led to better risk control and active awareness by ward staff of potential ligature anchor points and possession of ligatures.
I have not had opportunity to assess whether this is a one-off incident, or that there were further failings to complete other patient forms correctly. However, what I was able to ascertain was that these form completion failings, were not identified by any senior ward staff, during the 7 days Patient X was an inpatient.

There was no evidence of any monitoring of form completion or review of patient documents, to confirm that the content was complete and accurate, giving a full account of any issues staff needed to be alerted to.

Whilst I appreciate actions have been taken to complete patient risk assessments and treatment plans, you will need now need to assess through effective monitoring, whether the quality of these documents, meet the requirements of your admissions policy."

Response:

Risk Assessment Training
The Wales Applied Risk Research Network (WARRN) is a formulation-based technique used to assess and manage serious risk including violence and suicide for mental health service users. WARRN has been available since 2011. The Health Board has recently agreed WARRN as a mandatory training competency and this will support with collecting an agreed training compliance. WARRN is aligned to the Acute Care Operating Framework and this framework is in place.

Documentation Audit
The MHLD Division arranged for an external team to the Hergest management team to carry out a full patient audit of risk assessment and documentation on 19th and 20th July 2022.

These outcomes will provide a baseline, together with agreed actions for improvement, with external re-audit and testing being undertaken every two months. Reporting of the results of the audit will be through to the MHLD Division Quality, Safety, Experience Group and then upward to the Health Boards Patient Safety Group and Strategic Occupational Health and Safety Group (SOHSG) chaired by myself. The SOHSG reports to the Quality and Safety Committee of the Board and can escalate matters directly to Board if required.

3.2 Bed Safety

"At the time of Patient X's admission, I understand that there were no anti-ligature beds available on the ward.
I understand that there were no spare anti-ligature beds available within the main hospital store. It appears that no-one contacted any of the other wards to establish whether there was a spare anti -ligature bed.

The failing to conduct a thorough patient risk assessment, resulted in a lack of knowledge regarding Patient X's risk of suicide. Had this information been available, it would have influenced the bed allocation and/or period of observations.

Unfortunately, Patient X was provided with a hospital bed that offered a clear ligature anchor point at several locations, with notably a handle hold point within the headboard.

Following the reported incident on the 17th April 2021, a review of your risk management procedures, to consider the ongoing suitability of this bed, was not completed. Staff should have considered the risk presented by this bed, once Patient X had escalated her intention specifically towards hanging.
I appreciate that there is a mixed cohort of patients on Aneurin Ward, where some require manual handling aids and adjustable beds to support their independence. However, these factors need to be considered when admitting a patient who has expressed an intent to

commit suicide. Some of the risk controls that could have been in place include providing 1:1 supervision to Patient X until a anti ligature bed became available, or placing less mobile patients in a bay furthest away from those with more complex mental health issues.

I appreciate that post incident, BCUHB have created a new bed allocation policy and have removed all non anti-ligature beds from this ward.

An effective environmental risk assessment reviewing ligature anchor points should have been conducted prior to this incident. Had this have been done, it should have alerted staff to risks from using the type of bed provided to Patient X."

Response:

All profiling beds were removed from the Unit and replaced with non-profiling beds. However, there are occasions, following a bed assessment and a patient risk assessment, where it is appropriate and necessary to access a profiling bed; these could include bariatric/paraplegic/ neuro/severely physically impaired the and those requiring specific wound care. Head of Nursing (West) has confirmed there is currently one profiling bed in use within the Hergest Unit as at 03.08.2022. If a profiling bed is required a risk assessment is completed and accessed from the general hospital and returned immediately after use. Daily Acute care meeting minutes document the type of bed being used by individual patients.

On the 21.02.2022, the Health Board ceased the routine admission of patients over the age of 70 into the Hergest Unit. Any patient over the age of 70 who requires exceptional admission to the Hergest Unit requires the approval of MHLD Silver out of hours or MHLD Director in hours – any such admission must be supported by a Datix incident report. There is a re-direction process to other agreed hospitals of patients over the age of 70 years of age.

The Health Board is arranging for an external provider with the required experience and expertise to provide training to relevant staff in completing environmental anti-ligature risk assessments. Furthermore, the Health Board is arranging for an external provider to carry out a review of the environment related to ligature risk in the Hergest Unit.

3.3 Ligatures -Removal of property

"The lack of a clear patient management plan is also highlighted in the fact that Patient X was provided with the ligature used on the 20th April 2022, by ward staff. This ligature used was a blue tie belt used for a dressing gown.

Whilst there may have been good intention to provide basic clothing to Patient X, who arrived with no personal possessions, consideration through thorough risk assessment and patient management planning, should have identified the potential use of the belt as a ligature.

This consideration of the dressing gown belt should have been made after admission, when it was first supplied.

The incident on the 17th April 2021 presented a second missed opportunity. The possession of a ligature, by a suicidal patient should have alerted staff to follow the health board's 'Searching Patients and their Property Policy' MHLD 0013.

At Section 1:1 'Principles' it states ' Indicators that may lead to the decision to undertake a search might include:
There is reason to believe that the patient is in possession of items that are potentially dangerous to their own health and safety or that of others – for example, drugs, alcohol, weapons, ligatures or other unsafe items.'

Unfortunately no search was completed and the ligature remained in Patient X's possession. Again this was not captured during routine monitoring of the patient records and not identified as relevant by any of the subsequent nursing staff who cared for Patient X between 17th April and the 20th April 2022.

In evidence, nursing staff varied in their responses regarding the possession of a ligature. Some had an outright lack of knowledge of this policy, others held (the wrong) belief, that the policy could not be applied to voluntary/informal patients. The status of the patient is clarified at point 4 of the policy, and clearly outlines that a property search can include informal patients.

You will now need to provide sufficient training to all ward staff, so that they are aware of your Searching Patients and their Property Policy.

Where property searches are completed, detailed notes should be retained in the patient record."

Response:

The Health Board has arranged for the existing Therapeutic Engagement and Observation Policy, Patient Search Policy, Restricted Items Policy, Patient monies and property procedure, Acute Care Operating Framework procedure to be updated. There is a tracking system to show the policy development and ratification process. Training slides are under development that give details on the main contents of relevant control documents.

4. Next Steps

A series of recommendations have been made by the Health Safety and Security team for focussed action required to address the specific breaches identified. In addition to the normal delivery and governance, the work to deliver against these recommendations will be overseen by dedicated group chaired by the Chief Executive.

In addition, a recommendation has been made to the Chief Executive for all members of the Health Board Leadership Team to be required to attend the Institution of Occupational Safety and Health (IOSH) Leading Safely training and for this to be a mandatory requirement for all managers 8d and equivalent and above.

The purpose of this is to ensure that all senior leaders understand the remit of Health and Safety legislation, including that relating to patient care, and are equipped with knowledge of the responsibilities associated with this legislation.

Teitl adroddiad: ***Report title:***	The Implementation of a Mortality Review Structure to Support the Medical Examiner Service			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022			
Crynodeb Gweithredol: ***Executive Summary:***	*This is a summary of the work already done to implement a robust mortality review process in a hospital setting and an update on progress in extending this to primary and community care. This will inform learning and contribute to the developing Quality Strategy*			
Argymhellion: ***Recommendations:***	*The Commitee is asked to note the report*			
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director			
Awdur yr Adroddiad: ***Report Author:***	Dr Damian McKeon, Associate Medical Director (Mortality)			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☒	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☐ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:***				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***				
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	The mortality review process may inform information provided to HM Coroner			

Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	This does not apply as this is a part of quality improvement activity, however actions taken as a result of reviews may be subject to EqlA and will be reviewed as neccessary
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary ben undertaken?***	This does not apply as this is a part of quality improvement activity, however actions taken as a result of reviews may be subject to EqlA and will be reviewed as neccessary
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	The mortality review process does not have a risk associated with the review process itself, but may inform new risks or mitigations against existing risks
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	No direct implications from the mortality review process, but actions may have implications and will be subject to the normal approval process
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	No direct implications from the mortality review process, but actions may have implications and will be subject to the normal approval process
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The paper has been discussed at mortality groups
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	None
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations*** Next steps include quality assurance of the existing processes and the development of more consistent review across the whole Health Board. Further work will then be needed to ensure that the learning from reviews is fully captured and contributes to the priorities within the Quality Strategy	

Rhestr o Atodiadau: Dim ***List of Appendices:*** *None*

Guidance:

Quality, Safety and Experience meeting in public
6th September 2022

The Implementation of a Mortality Review Structure

1. Cyflwyniad / Cefndir
Y cyd-destun sy'n esbonio pam fod yr adroddiad yn cael ei gyflwyno i'r Bwrdd/Pwyllgor, unrhyw gamau ymgynghori blaenorol, a'r pwrpas o'i gyflwyno i'r Bwrdd

Introduction/Background

Since October 2021, the All Wales Medical Examiner Service (MES) has been reviewing deaths independently from Betsi Cadwaladr University Health Board (BCUHB).

Recent data from the MES, demonstrates a sharp rise in cases reviewed and returned to the Health Board. BCUHB is the only Health Board (HB) in Wales where 100% of deaths from acute sites are reviewed, and latest figures reveal 250 deaths per month.

Of these, where learning is potentally identified, the MES returns the review to the HB for further actions. The decision to then further review, and the actions from that review, are responsibility of the HB.

2. Corff yr adroddiad / *Body of report*

BCUHB has the highest number of returned MES reviews (circa 38%). The MES has recently written to the HB to inform that they are also going to look at community deaths and deaths in primary care.The letter also reminded the HB that this is likely to be a statutory obligation by April 2023.

In 2021 the HB appointed a Associate Medical Director (AMD) for Mortality (0.4 WTE) and a Mortality Facilitator (1.0 WTE).

The output from this team has both been operational and strategic. The operational role is to receive the ME referrals into a dedicated inbox, and 'sieve and sort' them in an appropriate time frame. The options are then to potentially close the case if no opportunity for learning is percieved, or direct to the established governance arrangements, such as the Patient Advice and Liaison Service (PALS), Putting Things Right, (PTR) Covid Inquiry, so not to duplicate current structures or start parallel investigations.

Those where there is an opportunity for significant learning are sent to the established mortality hubs. In the last year mortality hubs have been created in all acute sites, all area sites, mental health,Welsh Ambulance Service (WAST), community and nursing homes

Each site then will review the case at a Mortality and Morbidity meeting to capture the learning. To ensure widespread distribution of the learning, and to reduce preventable deaths reoccuring from the same incident, each hub is encouraged to present the case and learning at the ' Learning from Mortality Panel' (LFMP).

This is an inclusive learning network that meets fortnightly on TEAMS. It has a wide representation across the HB including WAST and nursing homes.
It is a multi-professional forum and has formal reporting from Inquests, Womans, Paediatric mortality reports and close links with both Governance and Clinical Effectiveness. As well

as learning from the ME reports, regular Risk adjusted Mortality Indicator (RAMI) CHKS reports are submitted . Work is ongoing to capture ‘quick wins’ , and ensure the cases discussed and outcomes of discussions lead to change in practice to improve the quality of care.

The panel has led to change in a number of areas in the last six months including:

- Standard Operating Procedure (SOP) for referral to tertiary transplant centres,
- Inclusion of ‘cause of death’ discussions at board rounds
- A review of staffing in frailty units.

Other benefitis include fostering of closer working between area and site in the creation of a unified mortality hub in Central, and the development of a mortality network across BCUHB from M&M’s to enable services to link up and contribute to the LFMP. Quality assurance of the effectiveness of the changes introduced is now being developed.

A ‘Reducing Preventable Deaths’ conference will take place in Q1 2023/24. It is hoped that this will further encourage candor, openess and reflection from teams and services across BCUHB.

The LFMP also allows identifcation of themes where similar issues present, current themes have contributed to include supporting work around improving End of Life Care and decision making in ‘Do Not Resusitate’ (DNAR) Orders. Where services are facing challenges, reports around mortality from both cases and CHKS have been able to be produced to support ongoing work.

Strategically, BCUHB contributes to both the All Wales National Working Group and Steering Group on Mortality, shaping the development of the National Framework. There is also a regular interface with the ME service to discuss cases and processes and provide the necessary feedback to the ME service.

Currently from 2022, there is full compliance with the above.

There remains a backlog of approximately 500 inherited cases from 2018-2021, that have not been fully screened due to little information being available on the submitted cases. A sampling of these cases has taken place and no significant themes identified and therefore, in keeping with other HBs the review process will now focus on new cases.

BCUHB needs to demonstrate that it communicates effectively, innovates, values and respects and puts patients and their bereaved families first. There will be times either due to systemic failure, under resourcing, individual error or cultural behaviour where preventable deaths occur. When this happens, the response has to be one of full candor, empathy and openness to the bereaved. As well as this, there needs to be systems in place where that learning is captured and distributed across the whole HB so that further deaths are prevented. Therefore, coming together in the LFMP, which is inclusive of the whole HB, is imperative and the learning and change distributed is fundamental. Recording and documenting the learning is key to demonstrating that BCUHB has organisational memory and that avoidable occurrences are not repeated.

3. Goblygiadau Cyllidebol / Ariannol / *Budgetary / Financial Implications*

None apart from any new work identified as a result of the learning

4. Rheoli Risg / Risk Management

None apart from any new work identified as a result of the learning

5. **Goblygiadau Cydraddoldeb ac Amrywiaeth / *Equality and Diversity Implications***

None apart from any new work identified as a result of the learning

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

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, Deputy Exective Director of Nursing – Chair (on behallf of Gaynor Thomasson, Interim Executive Director of Nursing and Midwifery)
Date of meeting	16th June 2022
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	6th September 2022
Presented by	Angela Wood, Executive Director of Nursing and Midwifery

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

Division reports:

- Recruitment: Highlighted staff shortages across the HB
- Increase in complaints: common themes: Communication, access to appointments

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

Patient Story: A powerful story presented via a video of Mrs W's experience before, during and after her treatment within the maxillofacial department at YGC. Since the patient had her procedure, the Patient Information Readers Panel has reviewed all preoperative maxillofacial leaflets, they are now in circulation, pre-op, and post-op. Overall, the patient was happy with her treatment and sent a thoughtful gesture of chocolates and cards into the department.

Bereavement Quality Sub Group: There is going to be an overarching model specification, which is due to be published on the Welsh Government website later this month. Implementing the swan model for end of life care in the health board is an on-going discussion. The proposal was updated in light of the Welsh Government information that had been released. Therefore, the proposal is now up to date.

Childrens Report on Evidence of Learning from Baby Hunters Story: Sadly, Baby Hunter was born last May and sadly passed away in Alder Hey Hospital, Liverpool. This item was in relation to the parents experience they encounted on the neonatal unit.

In response to findings, work has been undertaken to look at implementing a finger print access to the wards; however, this needs to go through one more committee before we can progress with this. In principle, though it has been agreed, it will actually be Bluetooth access.

West Acute: There is an increase in complaints to the organisation and the team are struggling to respond in an efficient time. The process is currently being reviewed.

Central Area: Staff changes have been identified as an issue within the departments; however, this is being reviewed and support and a resolution being explored. Work is happening around capturing the service user's views from Pharmacy and medicines management and community dental as well as all the good work around the routine audits.

Carers Update: As part of raising awareness for carer's week, a series of videos were launched onto social media. NEWCIS an organisation who support unpaid carers now have their Hospital Facilitators based in the PALS Hub once a week.

Long COVID Experience Group: The long COVID Lived Experience Group are working closely with patients who are suffering with long COVID as they are helping with shaping the pathway. A new clinical tool is being developed to use with our patients who have long-term complex conditions. The tool is called an Outcome Star. The outcome star tool will help us to provide holistic services that provide support across all the areas of a person's life that may be impacted by their condition.

Engagement Update: There is currently engagement underway around the clinical services strategy, which is being led by Colin Fitzpatrick and Nick Lyons. Session are taking place with the local Authorities and the new councillors that were appointed in May 2022.

2 Achievement – include any significant achievements and outcomes

Childrens Report on Evidence of Learning from Baby Hunters Story: We have now been able to move forward with the visiting guidelines and in the next couple of weeks the extended family members will be included in the visiting process.

Engagement - Armed Forces Day is on Saturday 18th June so the team are supporting our Armed Forces leads and that is taking place in Wrexham

Quality, Safety and Experience Committee 6th September 2022	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Advisory Group Chair's Report

Name of Advisory Group:	**Strategic Occupational Health and Safety Group**
Meeting date:	**21 July 2022**
Name of Chair:	**Sue Green, Executive Director of Workforce and Organisational Development**
Responsible Director:	**Sue Green, Executive Director of Workforce and Organisational Development**

Summary of key items discussed:	HSE Inspection, Patient Handling and Patient Falls risk assessments Following the further HSE inspection of patient handling and patient falls risk assessments undertaken on the Wrexham Maelor Hospital site on the 18th of May 2022, work has continued on the wards to support staff completing these assessments. Trials on how to best support this had been undertaken and a report describing the outcome of these trials was presented. The most effective model had a combination of train the trainer (Ward Manager) and one to one bedside learning with staff directly. This model gave the best improvement in retained knowledge, detail on risk assessments and timeliness of completing these risk assessments. The HSE have seen this model and approve however they advised it must be done with pace. This training is in addition to the training available on ESR. HSE Investigation, Hergest Unit A notification of contravention letter was received 9 May 2022, to detail material breaches identified following the investigation of the death of a patient by ligature in the Hergest Unit. The material breaches detailed the standard of the ligature risk assessment, the bed and the ligature used. A further letter was received 15 May 2022 requiring the Health Board to provide a statement of explanation to accompany the HSE case to their independent legal team for consideration of further enforcement action. There is the potential for prosecution so a strategy for a response was required which will determine whether BCUHB defends its position or accepts liability and pleads guilty. With the engagement of the legal team and members of the MHLD team a response to both letters had been drafted. Since the last Strategic Occupational Health and Safety Group meeting, the response to both letters have now been sent and further feedback is awaited from the HSE.

	HSE investigation Llandudno Facilities Manual Handling Training An anonymous complaint was made to the HSE regarding a lack of manual handling training for facilities staff. The H&S team, to support the facilities team, have provided additional training and facilities management have been encouraged to stagger the refreshers to lessen the impact on the service when renewals are due. An initial response has been provided to the HSE and this remains under investigation. Cwm Taf Morgannwg Unversity Health Board (CTMUHB) Prosecution CTMUHB were recently prosecuted under sections 3, and 33 of the Health and Safety at Work etc. Act 1974. This is following the death of a wandering patient who absconded from a Ward and slipped on icy ground sustaining serious head injuries which sadly led to the patient death. The section 33 prosecution was in relation to a previous Notification of Contravention served on CTMUHB for failure to control wandering patients and reasonable action had not been taken to prevent this from recurring. The fine was £850,000 and PB advised that there is evidence of a change in the HSE approach to healthcare in Wales, and we are likely to see more penalties and prosecutions. Health and Safety Q1 report In addition to the three BCUHB HSE investigations, key points discussed from the Q1 report included: ▪ The number of RIDDOR reports made in Q1 was comparatively lower than usual, however there were still six patient falls reported and eleven staff injuries (appendix one) ▪ Incidents of violence and aggression have increased and a security business case has been submitted. ▪ Fit Testing Team have trained 22 new fit testers in Q1, including 6 Local Authority employees who will be supporting care homes. 1083 staff were fit tested in Q1. Three Year Health, Safety and Security strategy The strategy was presented to the meeting with the priority to embed this work within the organisation. A project manager has been appointed to support this strategy, along with other workforce and organisational development strategies, into the Operating Model. The focus in year one will be on the ten key elements identified in the strategy detailed in appendix two. Divisional Reports Written reports were presented to the meeting from Estates and Facilities, Area West, Area Central, Ysbyty Gwynedd, Ysbyty Wrexham Maelor, MH&LD and Women's Services. No reports received from Area East and Ysbyty Glan Clwyd

	Security Management Group The terms of reference for the new Security Management Group were discussed. This is a strategy and management group reporting directly to the Strategic Occupational Health and Safety Group and key attendees will need to be identified by senior managers.
Key advice / feedback for the Board:	HSE It was previously noted that common themes are running through the HSE investigations and inspections and these should not be discussed and dealt with in isolation. One of the dominant themes is the standard of the risk assessments including the mitigation of the risk, control measures and reviewing and updating these documents to ensure the information is current and correct. Reviews of patient falls and handling risk assessments are still identifying inadequate assessments are being recorded. It is recommended that there is a significant focus on releasing staff for training that is being offered including Patient Handling refresher training (this also contains Patient Falls training), online e-learning, bedside learning and Train the Trainer courses. Mortuary and Body Store Security Security reviews have been undertaken in all body stores and mortuary facilities across the Health Board. Significant failings were identified relating specifically to access control and CCTV coverage. Work has been carried out on the Ysbyty Gwynedd site and will be replicated in Ysbyty Glan Clwyd and Ysbyty Wrexham Maelor. Concerns have been raised regarding the use of CCTV in body stores and viewing rooms. This will be addressed with a Standard Operating Procedure providing clear information and instruction on the use of recorded CCTV within the department. There is limited assurance for security controls in the community sites, the Security Advisory Team are supporting with options however, some sites may need to close body stores if the risks cannot be adequately mitigated. Ligature risk register A group was previously established to assess the completion of ligature risk register entry for across the Health Board. The group has not met for a number of weeks and progress on this was not known, it was recommended previously that this group is re-established. Risk register review/ BAF PB presented the current risks on the Board Assurance Framework with both Health and Safety and Security / Violence and Aggression remaining as scoring 20. The manual handling risk has been escalated to Tier 1 as training for staff is now at 49% and there remains a high number of staff failing to attend their booked training. Recruitment to these training and advisory posts has also been difficult and a plan has been implemented to supplement the training with the use of external training providers however this is likely to be very limited.

	Items for escalation ▪ The Legionella management system is reviewed by the Water Safety Group to provide assurance to the Strategic Occupational Health and Safety Group. Reports have not been received by an external competent auditor in a timely manner. ▪ Reviews of patient falls and handling risk assessments are still identifying inadequate assessments are being recorded. ▪ Evidence of non-compliance with Healthcare Building Notes and Healthcare Technical Memorandums has been identified on some construction projects including the replacement of footpaths on the Ruthin Hospital site. Compliance is required to ensure the safety of patients and staff and there have been accidents since this footpath was completed. ▪ In the new Integrated Health Communities structure there should be identified roles that take responsibility for areas such as fire, contractor control, water safety and asbestos on each of the hospital sites including community hospitals.
Targeted Intervention Improvement Framework Domain addressed	Leadership (including governance, transformation and culture)
Planned business for the next meeting:	In addition to the standing agenda items ▪ The model, timeline, actions and expected outcomes for the Three Year Health, Safety and Security Strategy will be presented ▪ Discuss the draft Training Needs Analysis for IOSH Managing and Leading Safely based on the new management structures ▪ Update on the HSE current investigations
Date of next meeting:	15 September 2022

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Appendix One – Summary of RIDDOR reports for Q1 2022/23

Patient fall	Identified controls on the risk assessment were not fully implemented
Patient fall	Identified controls on the risk assessment were not fully implemented
Patient fall	The risk assessment had not been updated following a previous fall
Patient fall	The risk assessment was partially updated following previous falls and further controls had not been identified
Patient fall	The falls alarm failed to activate and had not been checked prior to use

Over 7 day injury	Staff member sustained musculoskeletal injury turning a patient on their own
Over 7 day injury	Staff member injured their finger moving a trolley, they were unable to undertake their normal duties
Over 7 day injury	Staff member sustained a musculoskeletal injury moving furniture
Over 7 day injury	Staff member tripped over a bag
Over 7 day injury	Staff member assaulted by a patient
Over 7 day injury	Staff member tripped over equipment
Over 7 day injury	Staff member assaulted by a patient
Over 7 day injury	Staff member assaulted by a patient
Specified injury (fracture)	Staff member fall from an office chair with incorrect castors for the floor type
Specified injury (fracture)	Staff member pushed over by an aggressive patient
Over 7 day injury	Staff member sustained a head injury after being hit by a door kicked by an aggressive patient

Appendix Two - Three Year Occupational Health, Safety and Security Strategy

Year 1:

Occupational Health and Wellbeing

1. Stress Management Systems- Targeted Wellbeing activities focusing on the HSE Stress Management Standards of, Control, Demands, Support, Relationships, Role and Change, in order to influence deeper organisational culture to promote workplace wellbeing and resilience.
2. Targeted immunisation programme to address backlog and to ensure the provision of standard and specific programmes where and when indicated.
3. Health Surveillance- devise and deliver a compliant and best practice programme across all identified hazardous occupational exposures, including, skin, respiratory, noise and vibration.

Security/Violence and aggression

1. Violence, aggression and security training that is appropriate to the organisations needs and reduces risks in this area improving reporting and implementing controls.
2. Develop an effective robust fit for purpose Security structure and management system that reduces risks in this area of the business.
3. Lockdown procedures that include missing child events will ensure if a crisis does occur the organisation is ready for the event and does not create further issues.

Health and Safety

1. Manual Handling provision of appropriate policy and training.
2. Deliver an effective COSHH management system to key service areas.
3. Review the ligature risk assessment process and support the MHLD teams in undertaking these risk assessments.
4. Review RIDDOR reporting and management to ensure incidents are reported in a timely manner.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

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, Deputy Exective Director of Nursing – Chair (on behallf of Gaynor Thomasson, Interim Executive Director of Nursing and Midwifery)
Date of meeting	11th July 2022
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	6th September 2022
Presented by	Angela Wood, Executive Director of Nursing and Midwifery

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

WMH

In relation to theatres, there have been several concerns around standards, cleanliness and staffing. A 12-week rapid improvement program was put into place, which included a huge amount of work being implemented to correct this. This program is now closed and the usual governance framework around the management of theatres has been instigated.

YGC

YGC have entered a Targeted Intervention programme, initiated by Welsh Government. Two on-going concerns were with the Vascular Service and the more recent HIW Inspection for ED including the failure to escalate patients within ED.

An overall Improvement Plan has been developed which includes five different work streams. These five streams are Back to Basics, which will be led by Dr Balasundaram Ramesh as Medical Director. Neil Rogers will lead on the Leadership, Organisational and Development stream; Emergency Department Progress and Flow will be led by Paul Andrew; Vascular and Theatres will be led by Jane Woollard and Neil Rogers will lead on Audit Outcomes.

North Wales Managed Services

A HTA Inspection has taken place. There are a couple of issues around security and where the CCTV cameras are located which has been flagged. A discussion around this will be taking place while HTA are on site.

Central Area

The highest risk is the significant staff turnover factor in central area, which is currently at 10%. Progressing recruitment from agreeing the post to advert, in part due to delays from the Welsh Translation Team, has taken around 12 weeks, which is a huge risk especially for services such as Paediatrics.

The lack of a Psychologist within the Neurodevelopment Team is having an impact on children receiving assessments and increasing the current wait times.

East Area

There is currently a risk around HMP Berwyn, regarding the ability for men to access appointments or to be escorted to appointments on site. The prison team are trying to improve this, in particular around dental appointments.

Women's Services

The Women's Division advised they had suspended the home birth service due to the potential risk from ambulance delays. The division had undertaken due process and informed all stakeholders and was communicating individually with all affected patents. The situation will be kept under dynamic review. It should be noted that other services in Wales have also taken this decision.

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

Infection Prevention & Control Sub-Group

In terms of COVID during the month of June, there was an increase in activity across all sites, which resulted in re-instating COVID wards in all three acute sites. In response the use of mask wearing in clinical areas was re-introduced alongside testing on day 5 and day 6 of all our confirmed COVID patients using LFT's.

YGC has stepped down into Level 1 covid outbreak. All sites have had closed areas during this time.

Safer Medication Steering Sub-Group

Two incidents were reported as severe, one involved the wrong sticky address-a-graph on a prescription chart, resulting in the wrong patient medicines being administered. The

second was a vascular patient who was transferred from Wrexham. The patient had started on an IV heparin infusion but unclear if medication administrated as the pump stopped enroute. Initial learning from this incident identified the need for increased training around heparin infusions. Sessions have been arranged.

YG

It has been identified that around 15,000 patients are in excess of 52-week wait, there are over 6000 patients waiting for follow up appointments and around 4000 of those are currently overdue. Plans are being developed to reduce the backlog delays.

West Area

A Health Economy Task Force has been set up to address the concerns and impact on flow due to delays in medically fit for discharge patients being discharged. Initially the task force will be established for 4 weeks, directly supporting and mentoring discharge planning, and conversations with families. CHC Teams and the Home First Bureau will directly support the teams within the acute settings.

3. Achievement – include any significant achievements and outcomes

YGC

Abergele Hospital has returned to its pre COVID day case activity

North Wales Managed Services

An external assessment of blood sciences departments across all three sites took place, which is to an International Standard 15189. Feedback has been excellent with minor areas for improvement identified. Medical Physics have also had an external assessment against ISO 9001, with preliminary positive feedback.

Central Area

There is an improved CAMHS trajectory in relation to children's services with clinicians and ops teams working hard together with Helios supporting. Which is showing an improved positive impact.

Health Board *Insert date*	GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board *To improve health and provide excellent care*

Committee Chair's Report

Name of Committee:	Infection Prevention Sub Group (IPSG)
Meeting date:	**26 July 2022**
Name of Chair:	Mandy Jones, deputising for Gaynor Thomason
Responsible Director:	Angela Wood
Summary of business discussed:	• Mandatory surveillance performance data • COVID-19 update • PHW briefing on Respiratory Syncytial Virus (RSV) • Monkeypox update • Key Decontamination issues • IPT audits and frequency required • HCAI Awareness Campaigns • AAA reports from all areas • IP Annual Report • Update on Catheter Associated Urinary Tract Infection (CAUTI) programme • Estates and Facilities issues • Learning from Corporate HCAI reviews • Compliance with mandatory training in Q1 • New and updated IP policies and protocols
Key assurances provided at this meeting:	General • IP nurse staffing update provided: improving picture but current challenges in Central. • Further training sessions arranged for IP Champions arranged. IP Champions now in place in nursing homes in Central. • Good progress updating IP policies and protocols. • Compliance with mandatory donning and doffing PPE training rates have improved. • Plan to improve PIR process in Primary Care is progressing. • Positive staff engagement in the current SCC-HF 5S poster campaign with posters delivered and de-cluttering work started. **Decontamination:** • £0.5million funding identified to make some minor changes. • Mini-Pro Protein Testing Machines being implemented across BCU as per national recommendations. • Audits progressing as plan. • SOP for the Decontamination of Flexible Nasendoscopes and Decontamination of Medical Devices Procedure approved and uploaded onto BetsiNet.

	Estates and Facilities: • Estates SCC revenue allocation for 2022/23 for improvements is being prioritised through Local IP Groups. • Good compliance with latest water testing on Enfys ward following installation of automated showers. • Mandatory training compliance rates improved for IP Level 1. • Hypochlorus Acid now the first choice for high level disinfection of the environment replacing the use of HPV and UVC. This process is significantly faster and safer than HPV, also relying on less domestic resource. • New protocol approved for regular flushing of taps and showers that are used infrequently. • New Estates strategy in development.
Key risks including mitigating actions and milestones	• **C.diff**: 62 cases so far in BCUHB; this is approximately 34% more than the equivalent period in 2021/22 and BCU currently 4th of the 6 Welsh Health Boards. A Task and Finish group is to be established to review pathways, treatments, patient information etc. • **MRSA bacteraemia:** there have been 7 cases for 2022/23; there were 0 cases in the same time period for 21/22; BCUHB is currently 6th of the 6 Welsh Health Boards. Cases are being investigated to understand lessons and determine if they were avoidable or not. The IPT will be facilitating MRSA microteaching sessions over the next weeks. The revised MRSA protocol has been uploaded onto Betsinet. • **IP team resource Risk 4241:** 'Inability to deliver timely IP services due to limited capacity', scoring 15. Mitigating actions include recruiting to vacant posts, using IP Champions to promote IP, preparing a business case for expanding the current team, designing a development programme for existing IP nurses and promoting the Bangor University IP education programme amongst non-IP staff. • **Documentation regarding invasive devices:** not completed in all cases e.g. for catheters, blood cultures and vascular access devices. This issue is being included as a SCC-HF project later this year. Spot checks being completed by Matrons. • **Ward fridges**: very poor compliance; a high number of fridges inspected in June had high risk items left in there. Could lead to formal improvement notices and / or prosecution. Members to raise issue at Local IP Groups. Matrons asked to audit. To enquire re getting audit on IRIS. • **PHW Microbiology resource Risk 1319:** scoring 9; ongoing issues trying to recruit to vacant posts. Leading to a lack of representation at *Clostridium difficile* ward rounds. • **Sleep Angel mattresses:** cannot be appropriately inspected for internal contamination. IP to meet with company representative to see if there is an alternative to disposal. • **Lack of medical engagement with Corporate HCAI reviews:** to raise with Deputy Medical Directors.

	Decontamination: • Decontamination Risk 4325 'Potential that medical devices are not decontaminated effectively so patients may be harmed', scoring 16 unchanged. Action plan in progress. Seeking Agency Decontamination Consultant to develop Decontamination strategy and business cases. • Poor engagement from staff at Decontamination Group meeting. Local IP groups asked to review Decontamination issues and include in updates for IPSG. • ENT OPD - deadline for current usage of Tristel wipes was 30/6/22. Meeting arranged for WM on 11 Aug to discuss. Awaiting update from YGC. • IHEEM report for Endoscopy WMH highlighted significant issues including built environment not meeting current guidelines. • BCUHB need to consider the purchase of "Low Temperature" Sterilisation Unit for the reprocessing of Choledochoscopes / Laser Lenses / and all Medical Devices which are not compatible with High Temperature Sterilisation – business case required. SBAR in progress. • IHEEM report for urology at Central received with significant issues raised including training, COSHH, ventilation, and electronic track and trace. Training issues are being addressed. Further work/business case required to address other issues. • Ultrasonic bath at Central SSD not working since 2018 so unable to decontaminate certain equipment; it will have to be decontaminated at other SSDs. Business case required for new bath. **Estates and Facilities issues**: • Challenges with domestic capacity and cleaning - recruitment campaign and the current resource is being prioritised e.g. to outbreak areas, with support from IP. Increased turnover being seen and delays in recruitment process is resulting in the loss of appointed applicants. • Cleaning for Credits audits (C4C) not being completed in all areas – requires further discussion via SCC. • Clinical Waste returned to business as usual since COVID but compliance varies – more work to do to raise awareness. • Proposal for YGC to revert to disposable curtains within the acute site and the impact it will have on the current service – to be risk assessed and reviewed at the Local IP Group.
Targeted Intervention Improvement Framework Domain addressed	• Mental Health (adult and children) • Strategy, planning and performance • Leadership (including governance, transformation and culture) • Engagement (patients, public, staff and partners)

Issues to be referred to another Committee	• Summary from IPSG is also sent to PSQ.
Matters requiring escalation to the Board:	• Nil
Well-being of Future Generations Act Sustainable Development Principle	• PHW are supporting BCU with assessment of risks and identifying short and long-term priorities in Decontamination. • Promoting IP education programmes at Bangor University. • Estates and IP trialling new technologies including ATP testing, hypochlorous acid, mobile air purification units, automated hand wash systems and joint working with the University of Sheffield on environmental cleanliness forensics. • IP are supporting the agenda to reduce waste and environmental impact.
Planned business for the next meeting:	Range of regular reports plus: • Spending by E&F in relation to improving the environment/IP. • New Coagulase negative staphylococcus (CNS) blood culture dashboard to support the indication of blood culture contamination rates. • Revised tool for PIRs in community. • Progress with C.diff Task and Finish group. • Plan for Sleep Angel mattresses. • Review of MRSA bacteraemia cases. • Comparison of Pseudomonas bacteraemia cases with water sampling data.
Date of next meeting:	13 September 2022

Report title:	HMP Berwyn Health and Wellbeing Service Quality, Safety and Performance Annual Report March 2021 – April 2022			
Report to:	Quality and Safety Executive			
Date of Meeting:	6th September 2022			
Executive Summary:	This is an annual report for QSE outlining all aspects of quality, safety and performance in relation to our health and wellbeing services at HMP Berwyn. The Board is asked to note HMP Berwyn's annual report for 2021 – 2022. Since HMP Berwyn opened in February 2017 QSE has received an annual report to provide a yearly update of progress in the development of the Health and Wellbeing Services provided by the Health Board at the prison.			
Recommendations:	The Board is asked to: Note the annual report of Health and Wellbeing services provided at HMP Berwyn by the Health Board for 2021 – 2022 which outlines all aspects of quality, safety and performance			
Executive Lead:	Gill Harris			
Report Author:	Simon Newman Head of Healthcare, HMP Berwyn			
Purpose of report:	For Noting ☒	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☒ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☐ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
N/A				
Link to Strategic Objective(s):	Nil to note			
Regulatory and legal implications	Nil to note			

In accordance with WP7 has an EqIA been identified as necessary and undertaken?	No Nil to note
In accordance with WP68 has an SEIA identified as necessary been undertaken?	No Nil to note
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Risks related to HMP Berwyn are incorporated in the East Area risk register with the exception of dental service risks which are incorporated in the Central Area register. The risk register is detailed on page 13 of the report.
Financial implications as a result of implementing the recommendations	There are no financial implications to note. The health and wellbeing services at HMP Berwyn continue to be fully funded by the Ministry of Justice through HMPPS (Her Majestys Prison and Probation Service)
Workforce implications as a result of implementing the recommendations	Nil to note
Feedback, response, and follow up summary following consultation	The annual report provides a summary of the monthly Quality, Safety and Performance reports which are approved each month at the prison governance meetings and tabled for assurance at the monthly East Area quality meetings
Links to BAF risks: (or links to the Corporate Risk Register)	Nil to note
Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps: **Implementation of recommendations** No further action required	
List of Appendices: Full report as attached	

BOARD OF DIRECTORS MEETING IN PUBLIC

6th September 2022

HMP Berwyn Health and Wellbeing Service Quality, Safety and Performance Annual report March 2021 – April 2022

1. Introduction/Background

This is an annual report for QSE outlining all aspects of quality, safety and performance in relation to our health and wellbeing services at HMP Berwyn.

The Board is asked to note HMP Berwyn's annual report for 2021 – 2022.

Since HMP Berwyn opened in February 2017 QSE has received an annual report to provide a yearly update of progress in the development of the Health and Wellbeing Services provided by the Health Board at the prison.

The annual report provides a summary of the monthly Quality, Safety and Performance reports which are approved each month at the prison governance meetings and tabled for assurance at the monthly East Area quality meetings

2. Body of report

See attached

3. Budgetary / Financial Implications

3.1 There are no financial implications to note. The health and wellbeing services at HMP Berwyn continue to be fully funded by the Ministry of Justice through HMPPS (Her Majestys Prison and Probation Service)

4. Risk Management

4.1 Risks related to HMP Berwyn are incorporated in the East Area risk register with the exception of dental service risks which are incorporated in the Central Area register. The risk register is detailed on page 13 of the report.

5. Equality and Diversity Implications

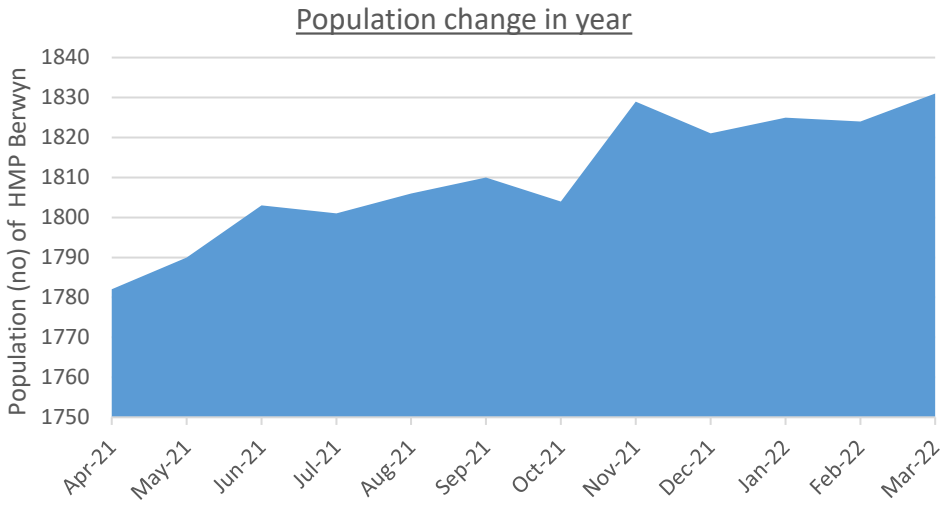
Nil to note

Health and Welllbeing Service
Quality, Safety & Performance

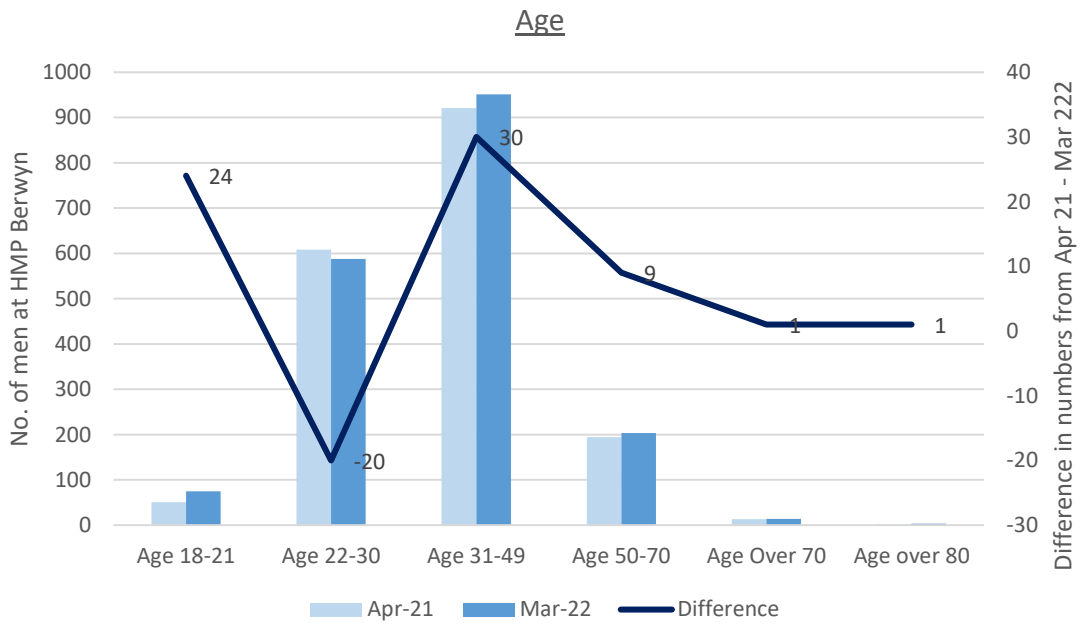
ANNUAL REPORT
MARCH 2021 – APRIL 2022

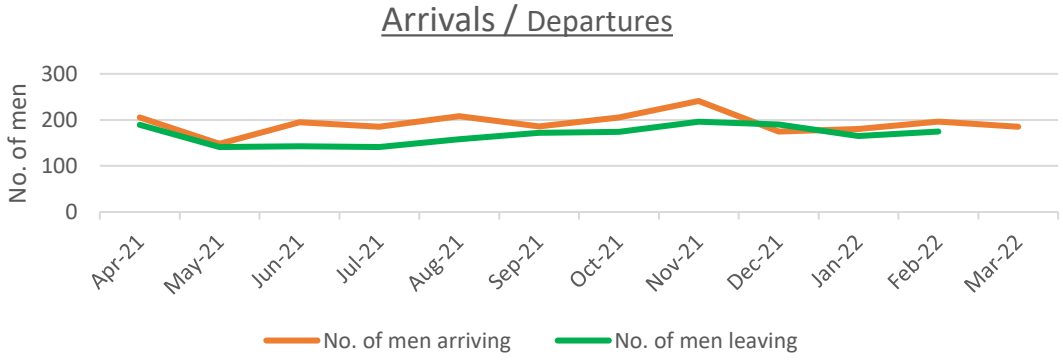
QUALITY

1. Demographics

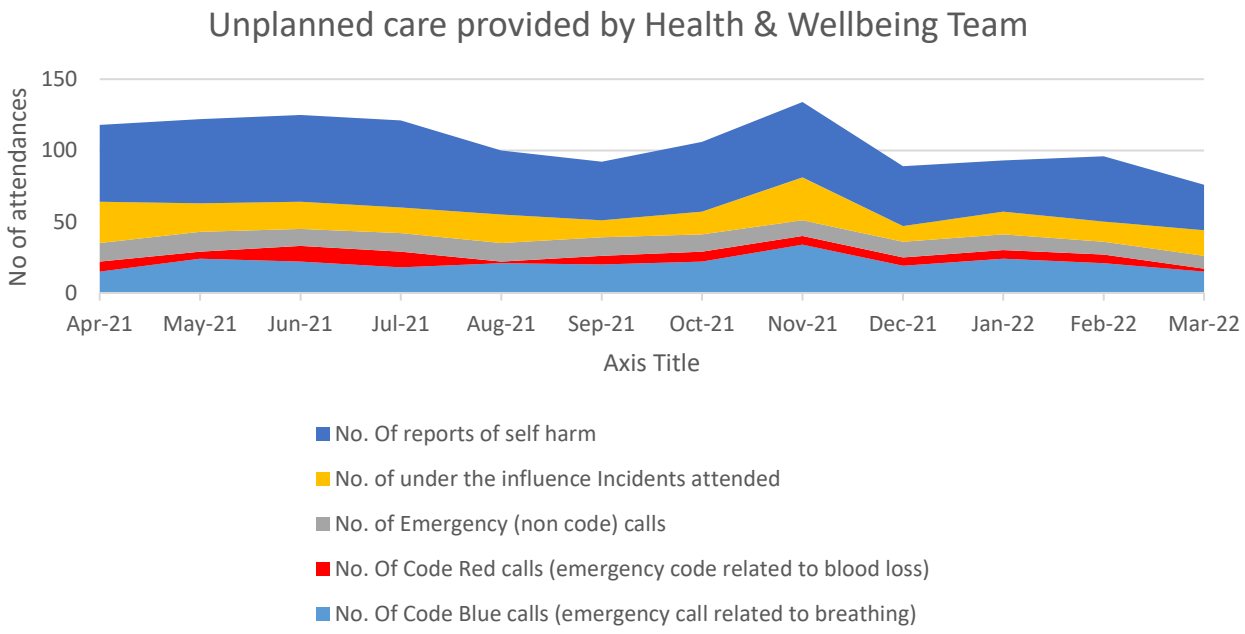


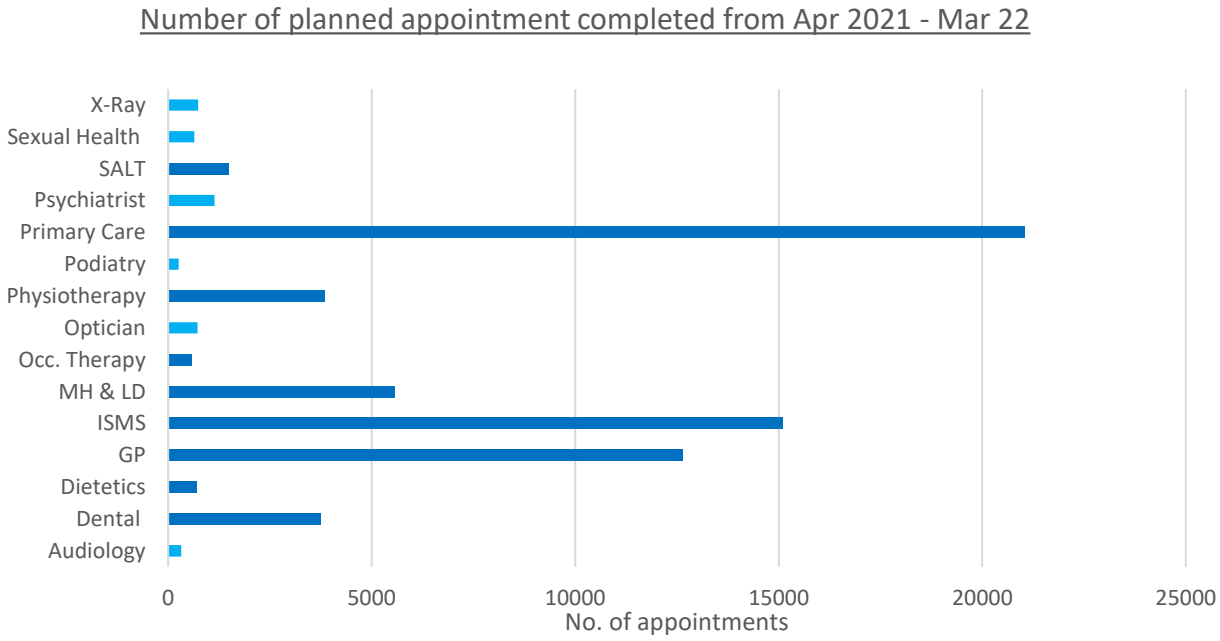
Capacity at March 2022 is 87%





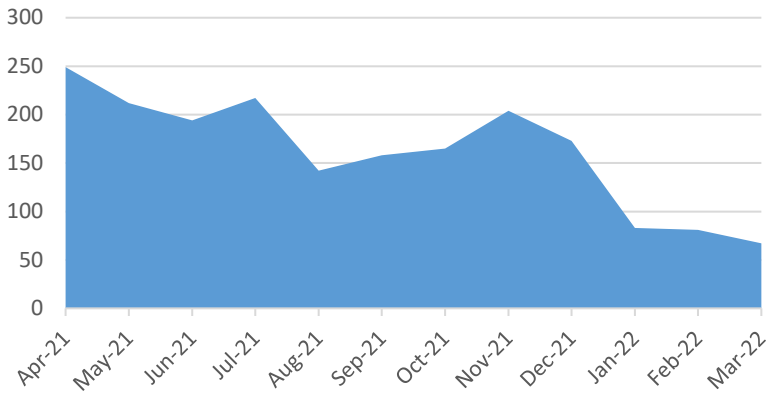
2. Service Delivery





68,518 planned appointments carried out on site at HMP Berwyn between April 2021 and and March 2022 across all services.

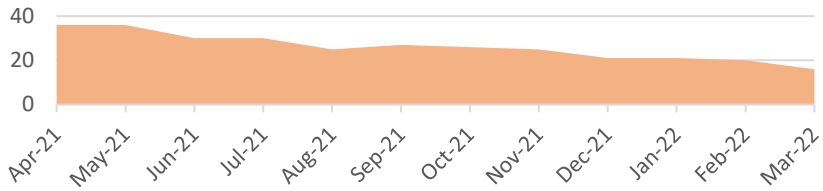
No. of routine referrals received by the MHLD Team



The MHLD Team have managed an average of 75 men per month who are registered under Part 2 of the MH Measure (Wales) over the last 12 months.

19 men have transferred to a secure hospital between Apr-21 and Mar-22 under the Mental Health Act.
The average waiting time is 40 days from assessment to transfer.

No. of referrals recevieved by the Substance Misuse Team



Between Apr-21 and Mar-22:
900 Hep C antibody tests completed with 9% returning a positive result.
254 Hep C PCR tests completed with 7% returning a positive result.

Introduction of Substance Misuse Digital Interventions which have been accessed by 842 men since Apr-21

Prenoxad Training delivered to 170 men prior to their release

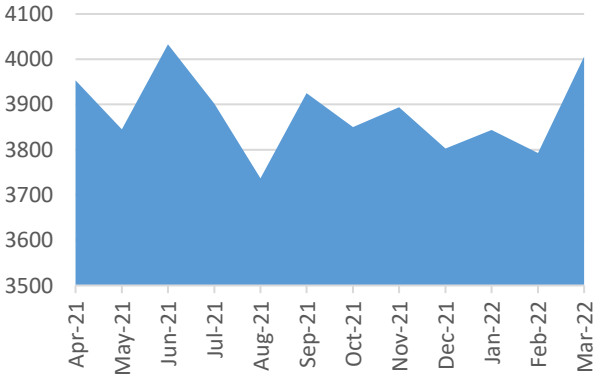
The Substance Misuse Team have had an average of 629 men on their caseload between Apr-21 and Mar-22

46,585 items prescribed and clinically checked between Apr-21 and Mar-22
86% were administered in-possession.

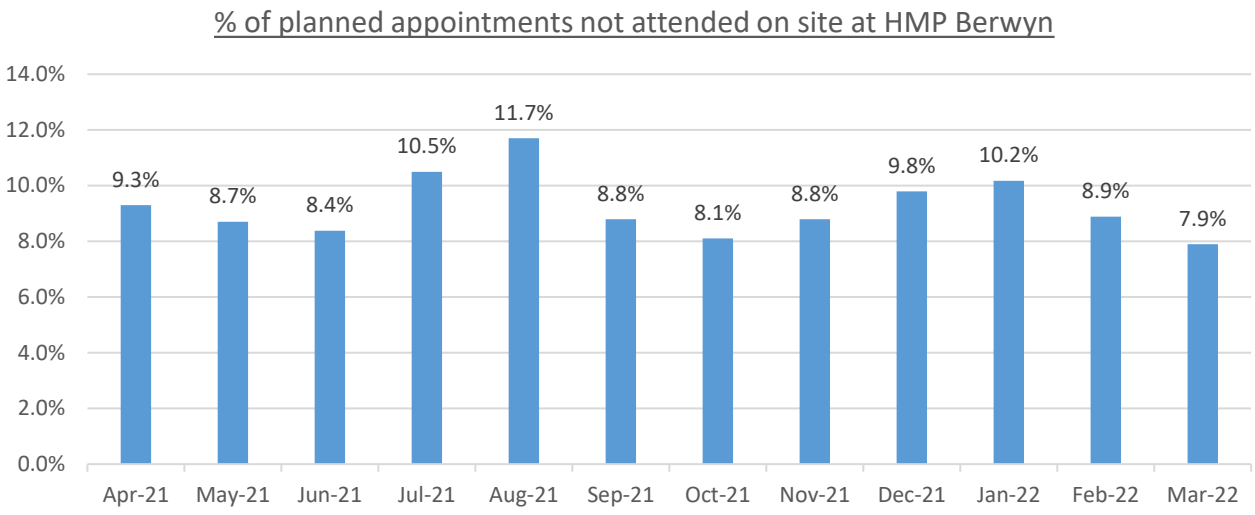
26 Medication Use Reviews carried out with patients by Pharmacists during 2021-22

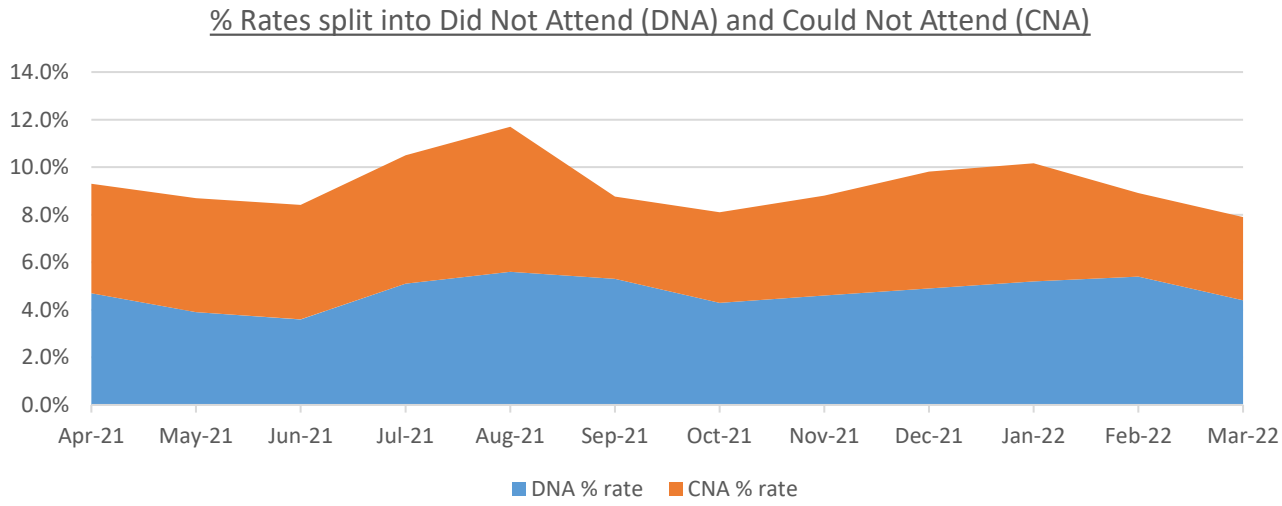
242 in possession medication room checks were carried out by the Pharmacy team with support of HMPPS

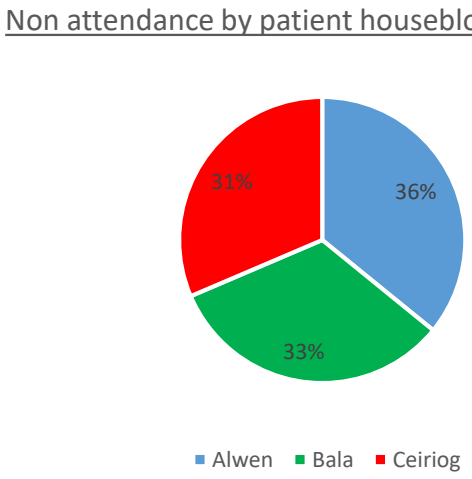
No. of items prescribed and clinically checked



3. Non-attendance at Health and Wellbeing Appointments



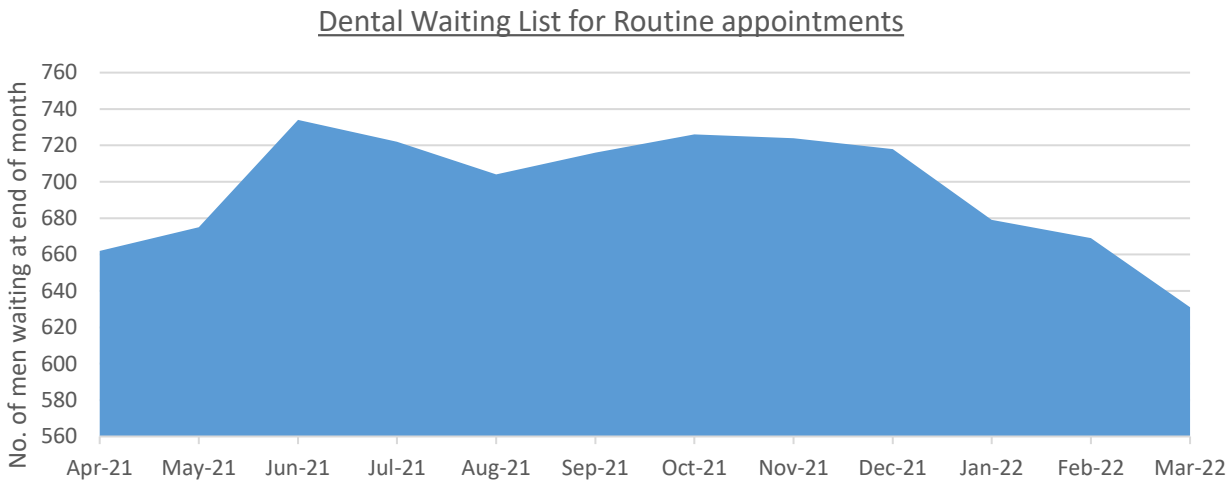




4. Waiting Time

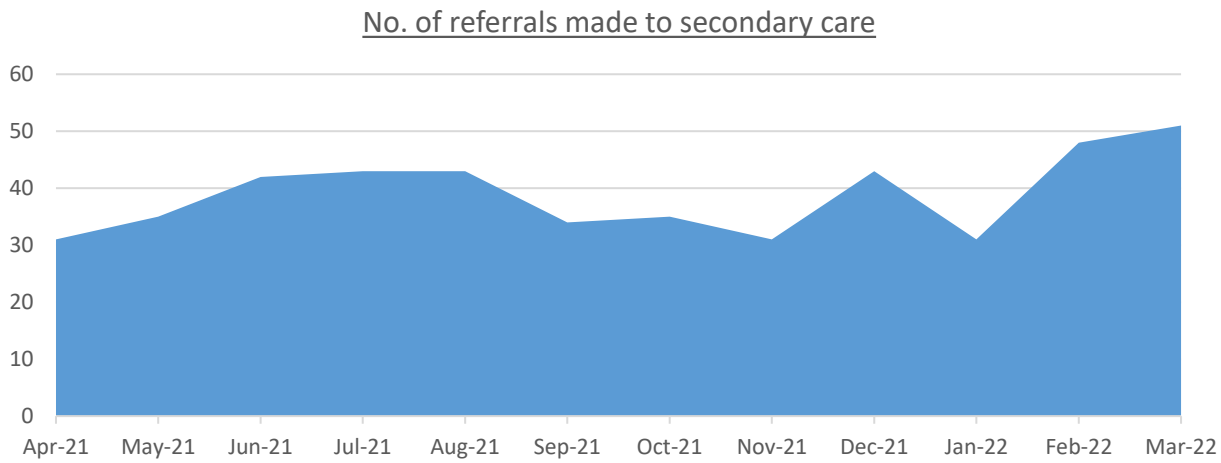
GP Waiting List initiative carried out during February – March 2022 which addressed an increased waiting list for routine face to face appointments following the COVID-19 Pandemic. The initiative saw the waiting time reduce from 16 weeks since application to 4 weeks in early March.

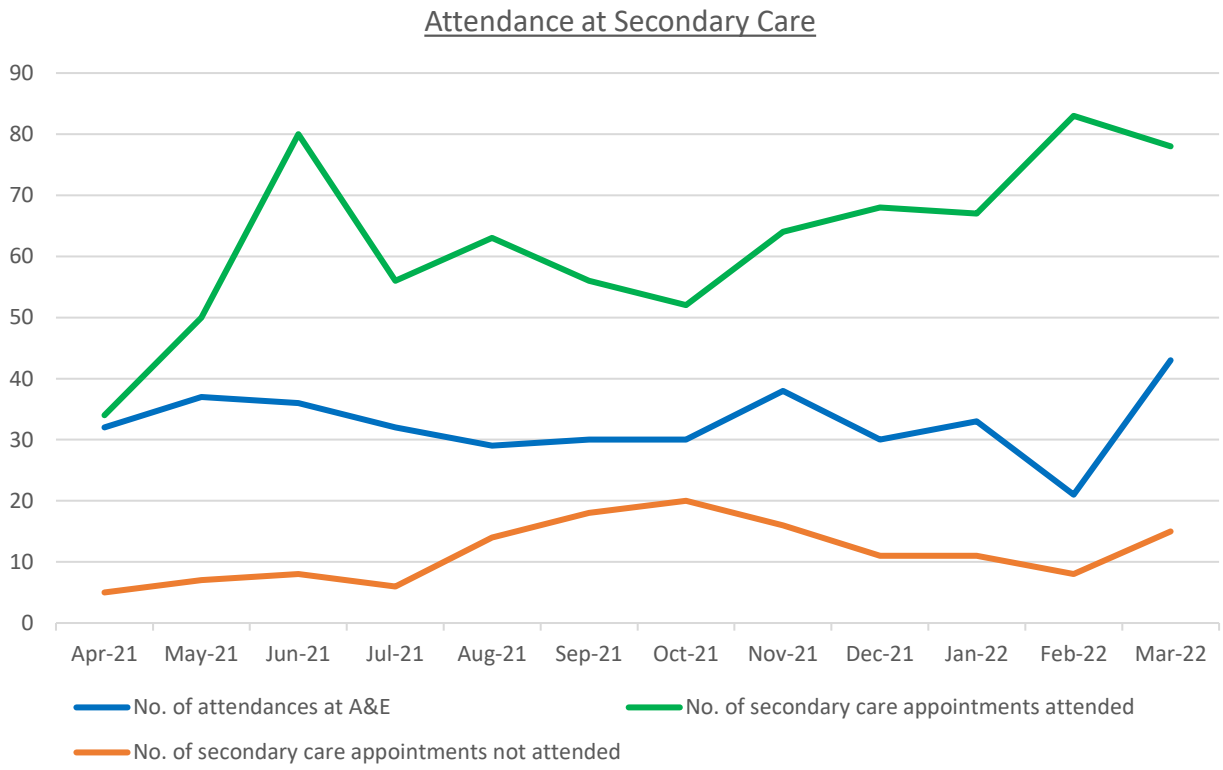
No breaches reported in referral to treatment (RTT) for Therapies team based at HMP Berwyn despite the Therapies team supporting the wider service delivery during COVID-19 outbreak period.



The length of time to see the dental team for a routine appointment continues to be high and is a risk on the risk register. This is due to COVID-19 restrictions in place in Wales in relation to the completion of aerosol generated procedures and additional infection prevention measures introduced during the Pandemic. The restrictions have been reduced from May 2022 which should show an improvement, however specialist equipment has also been purchased to enable appointments to be carried out in line with guidance. Additional dental appointments have also been supported over the lunchtime period by HMPPS which had increased the number of available appointments for patients.

5. Secondary Care



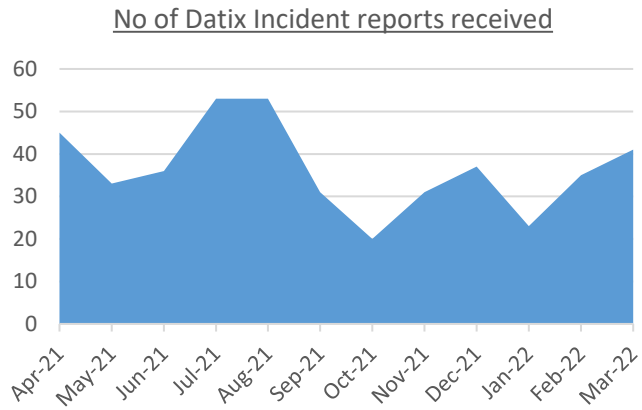


740 X-Ray's conducted on site at HMP Berwyn between Apr-21 and Mar-22

26 men have received MRI's on site at HMP Berwyn during 2022

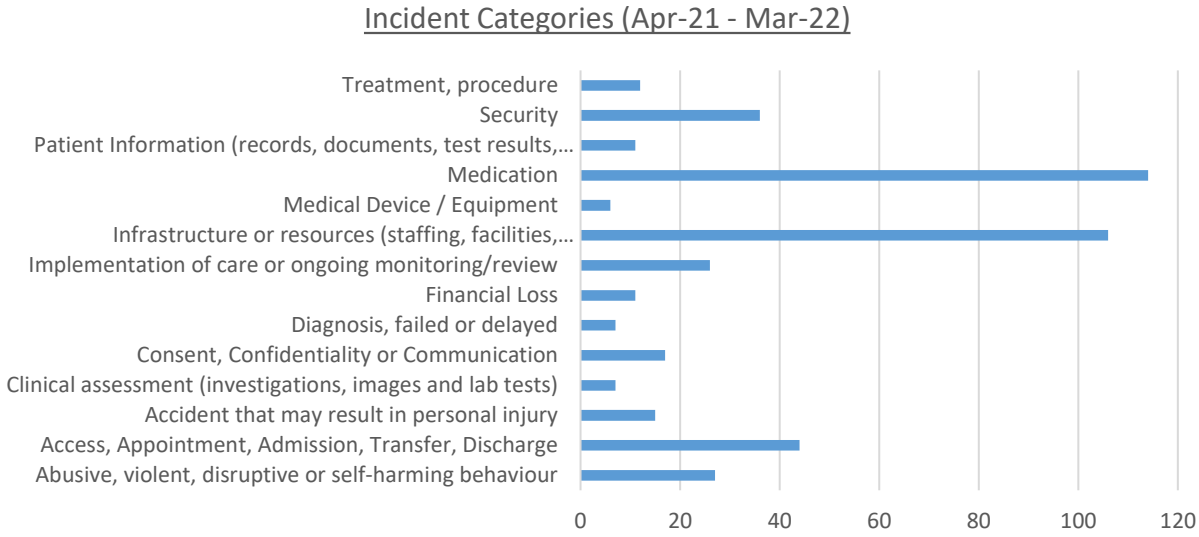
SAFETY

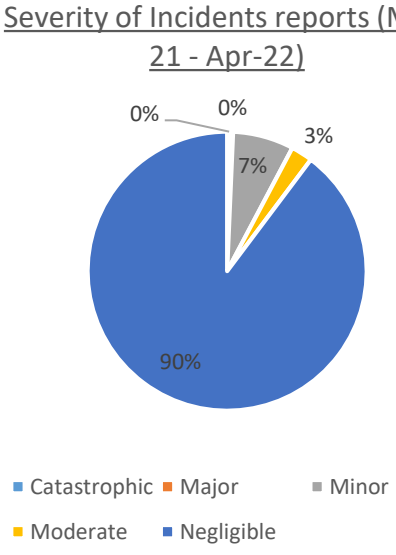
6. Incident Management

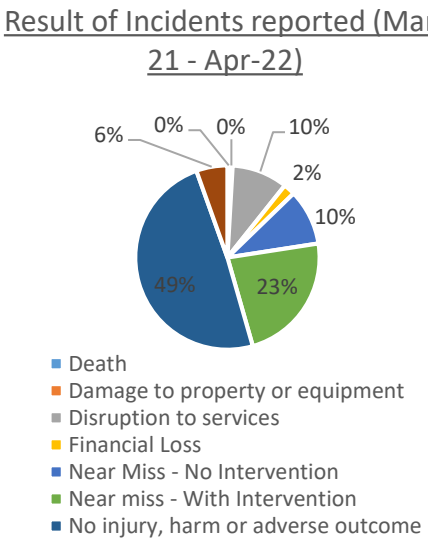


2 Death in Custody investigations completed between April-21 and March-22

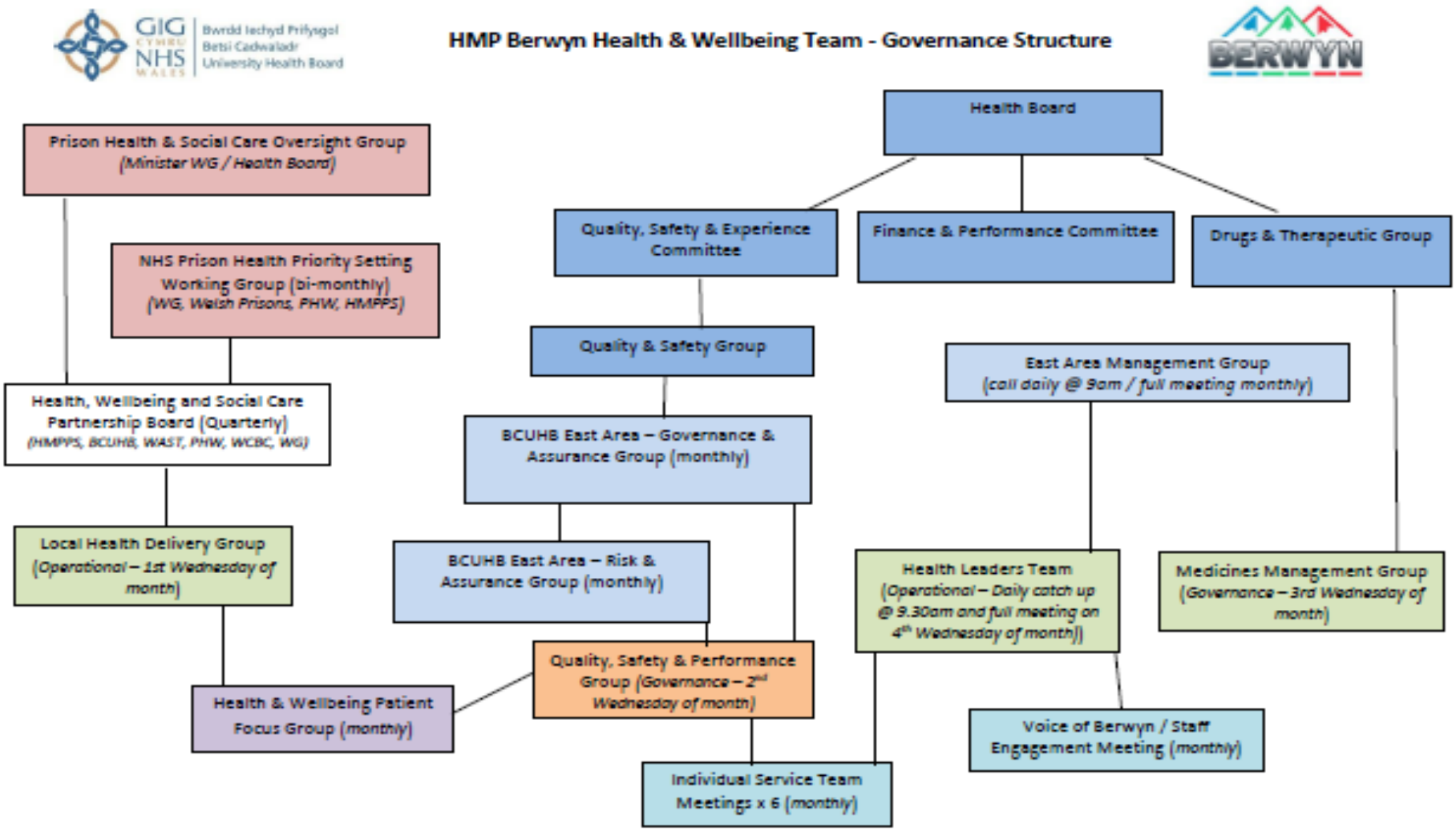
5 Make It Safe reviews completed following serious incidents between April-21 and March-22







7. Governance



Additional meetings attended by Health and Wellbeing Team at HMP Berwyn to demonstrate BCUHB insight of service provision:

BCUHB Patient Records Group – attended by Quality, Safety & Performance Manager
Information Governance Group – attended by Quality, Safety & Performance Manager
Area Planning Board – attended by Clinical Lead ISMS
Area Divisional Safeguarding Forum – attended by Deputy Head of Healthcare
Infection Prevention Sub Group – attended by Head / Deputy Head of Healthcare
Mental Health Division Clinical Strategy Group – attended by the Deputy Head of Healthcare
BCUHB Race Quality Action Group - attended by Head of Healthcare
BCUHB Gender Equality Network - attended by Head of Healthcare
BCUHB Strategic Occupational Health and Safety Group - attended by Head of Healthcare
All Wales Prison Health Clinical System Reference Group – attended by Quality, Safety & Performance Manager
East Area Therapy Management Group - attended by Head of Healthcare
HMP Berwyn Prison Executive Meetings – attended by Head of Healthcare
BCUHB Mental Health Locality meeting – attended by Lead Occupational Therapist
Occupational Therapists working in Welsh prisons forum - attended by Lead Occupational Therapist
Justice Based Occupational Therapists forum - attended by Lead Occupational Therapist
BCUHB Safer Medicines Practice Group – attended by Lead Pharmacist
BCUHB Mental Health Medicines Management Group - attended by Lead Pharmacist
BCUHB Pharmacist Managers Meeting - attended by Lead Pharmacist
BCUHB Controlled Drug Local Intelligence Network - attended by Lead Pharmacist
BCUHB Pharmacy and Medicines Management Workforce, Recruitment, Education and Training Group - attended by Lead Pharmacist
Medicines Safety Surgery – All Wales Medicines Safety Network - attended by Lead Pharmacist
Health & Justice Pharmacy Advisory Group Meeting (HJPAG) - attended by Lead Pharmacist

All therapy staff receive 4 / 6 weekly professional supervision from speciality leads in the BCUHB Therapy Service.

8. Staffing

Management Team / Support Services
Staff in post: 13.5 WTE Staff appointed / not in post: 1 WTE Vacancies: 3 WTE

Primary Care Team
Staff in post: 25.92 WTE Staff appointed / not in post: 1 WTE Vacancies: 15.46 WTE

Mental Health & Learning Disabilities Team
Staff in post: 19.4 WTE Staff appointed / not in post: 4 WTE Vacancies: 5 WTE

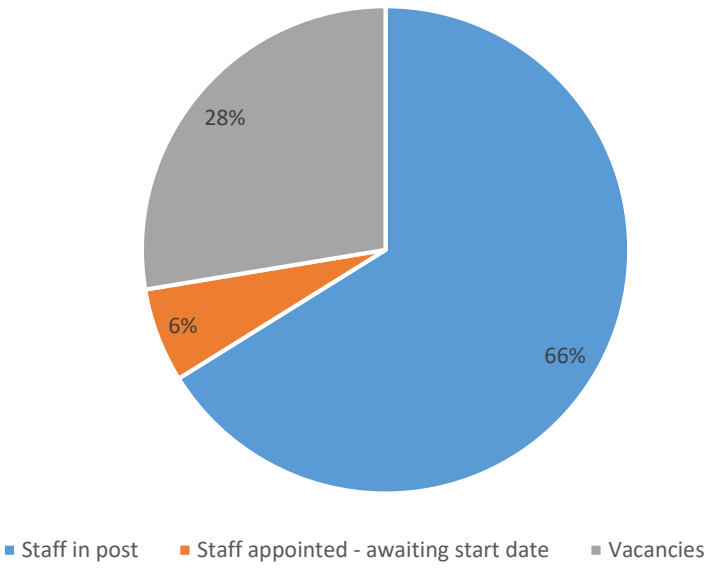
Substance Misuse Team
Staff in post: 19.01 WTE Staff appointed / not in post: 3 WTE Vacancies: 10 WTE

Dental Team
Staff in post: 3.8 WTE Staff appointed / not in post: 0 WTE Vacancies: 3 WTE

Pharmacy Team
Staff in post: 14.13 WTE Staff appointed / not in post: 1 WTE Vacancies: 4.2 WTE

Therapies Team
Staff in post: 5.6 WTE Staff appointed / not in post: 0 WTE Vacancies: 3.5 WTE

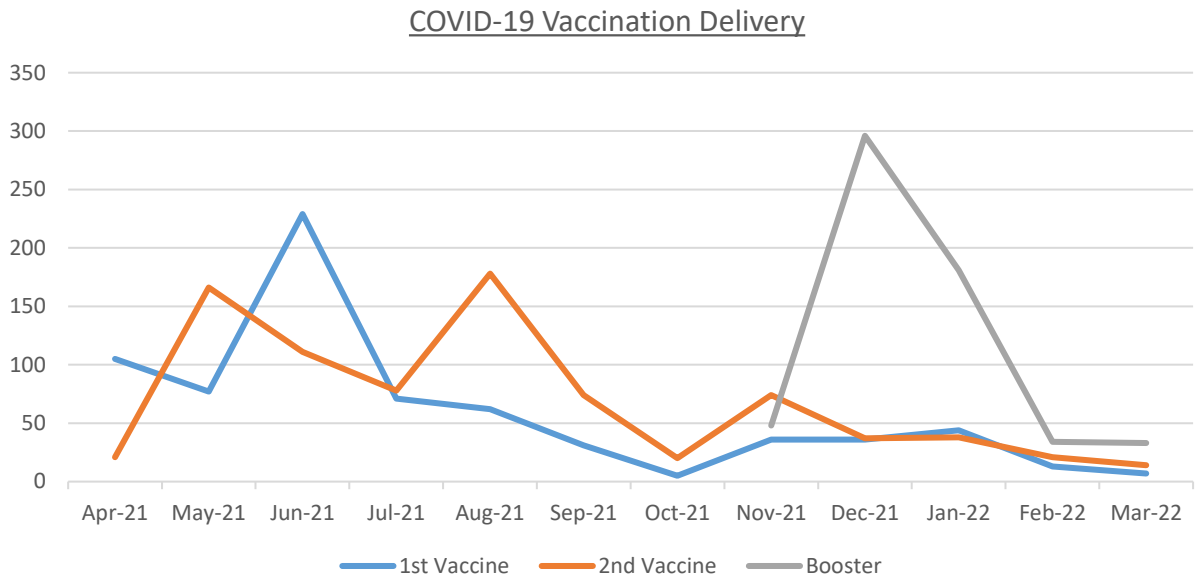
Sessional Staff
Staff in post: 4.47 WTE Staff appointed / not in post: 0 WTE Vacancies: 0 WTE

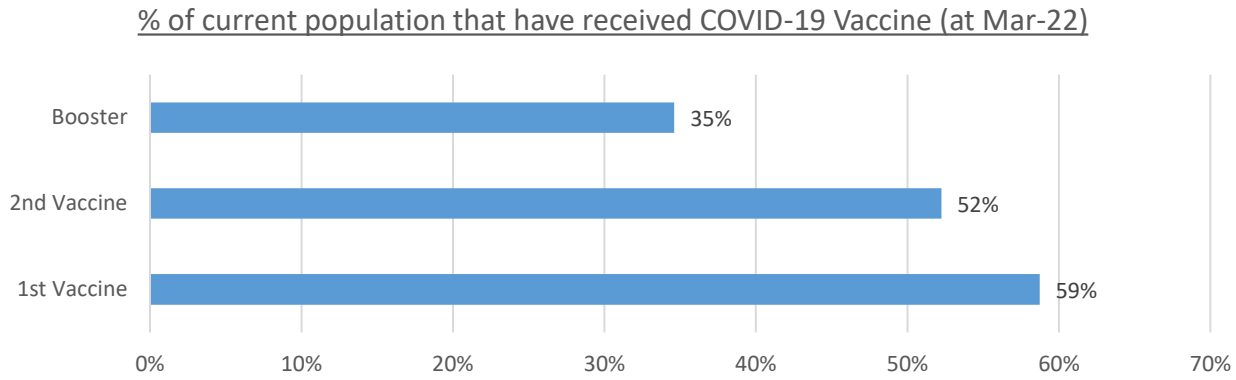


9. Risk

Identifier	Title	Score / Tier	Status
HMP16	Enablement issues by HMPPS impacting on delivery of Health and Wellbeing Services at HMP Berwyn	**Score 20 Tier 1**	Active
HMP15	Significant delay in treatment provision to HMP Dental patients	**Score 12 Tier 2**	Active
HMP4	Inability to enable timely admin of medication will compromise pt care/recovery & delivery of health and wellbeing service	**Score 12 Tier 2**	Active
HMP13	Inability to deliver stepped care model of MHLD Serv due to difficulties in recruitment & retention of skilled/experienced staff	**Score 9 Tier 2**	Active
TBC	Risk to patient safety due to the waiting time to access beds in secure settings for mental health and Learning Disability	**Score 12 Tier 2**	Approved at East Area – awaiting inclusion
TBC	Insufficient staffing levels within the Primary Care Team impacting on the delivery of Health and Wellbeing Service at HMP Berwyn.	**Score 12 Tier 2**	Approved at East Area – awaiting inclusion

10. COVID-19



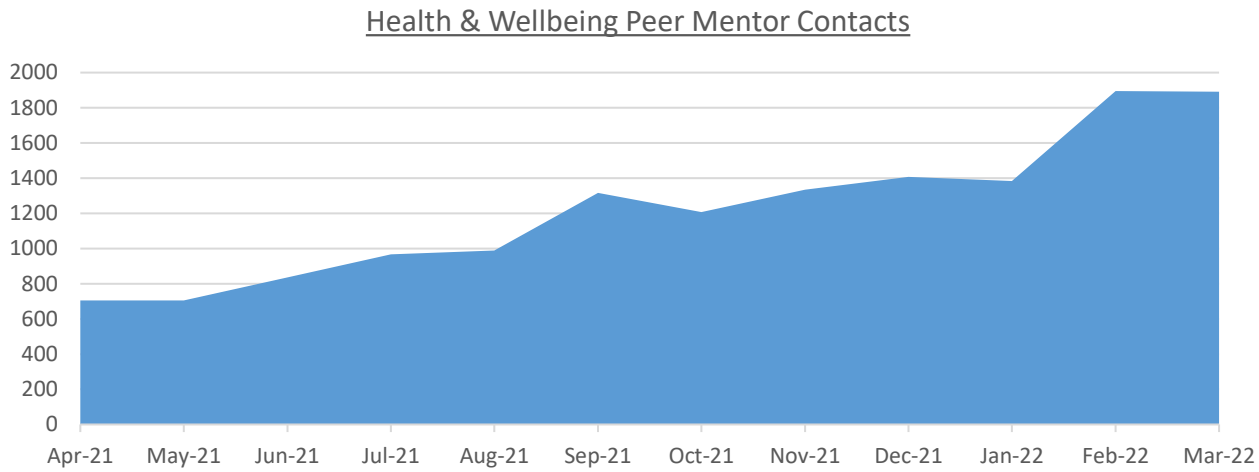


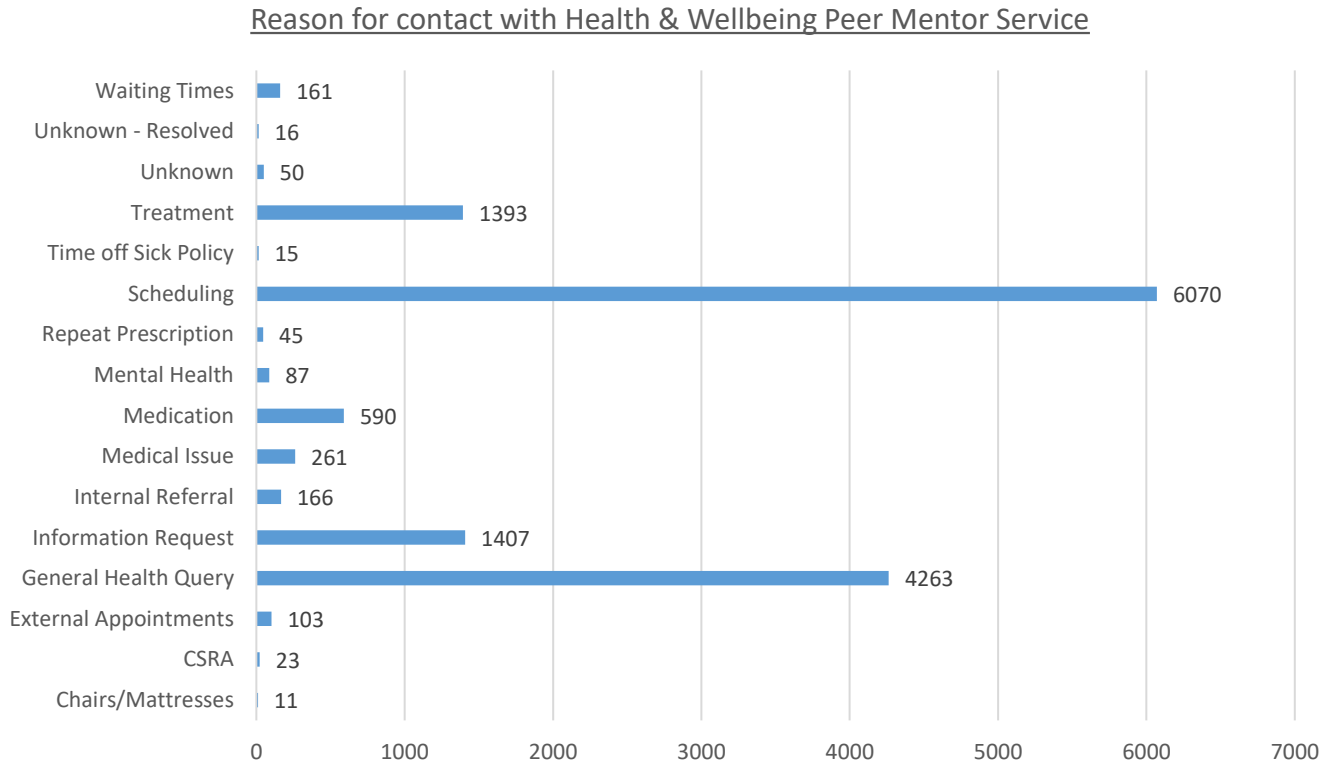
2525 new arrivals at HMP Berwyn have received PCR Tests between Apr-21 and Mar-22 with 59 positive results (2%).

648 men have isolated due to being symptomatic or sharing a room with someone symtomatic between Apr-21 and Mar-22.

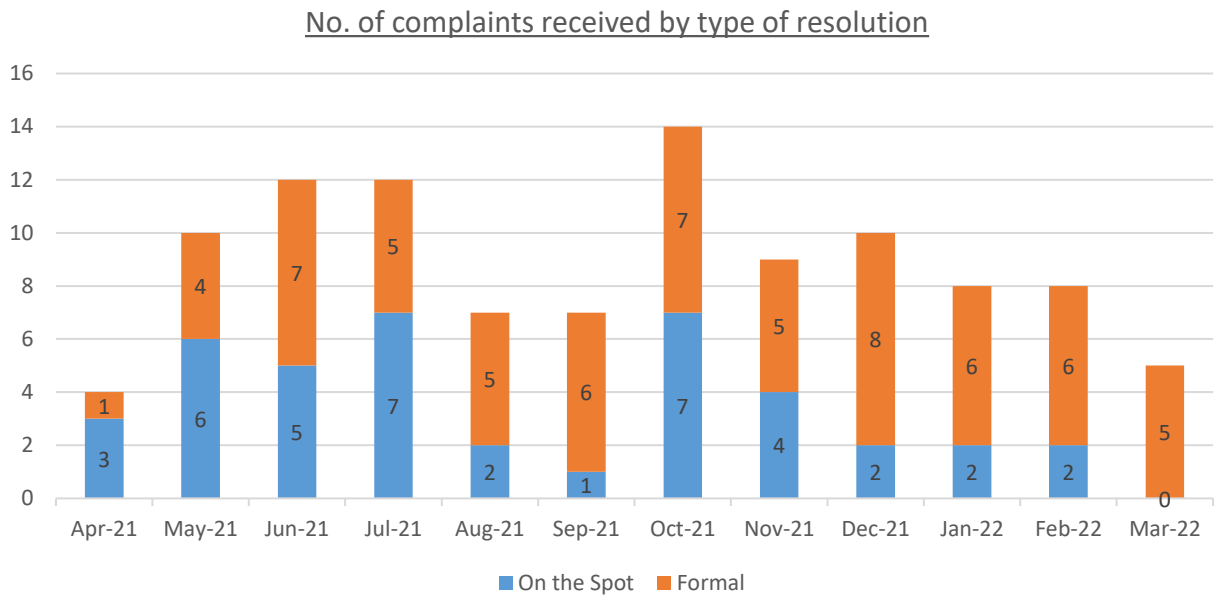
EXPERIENCE

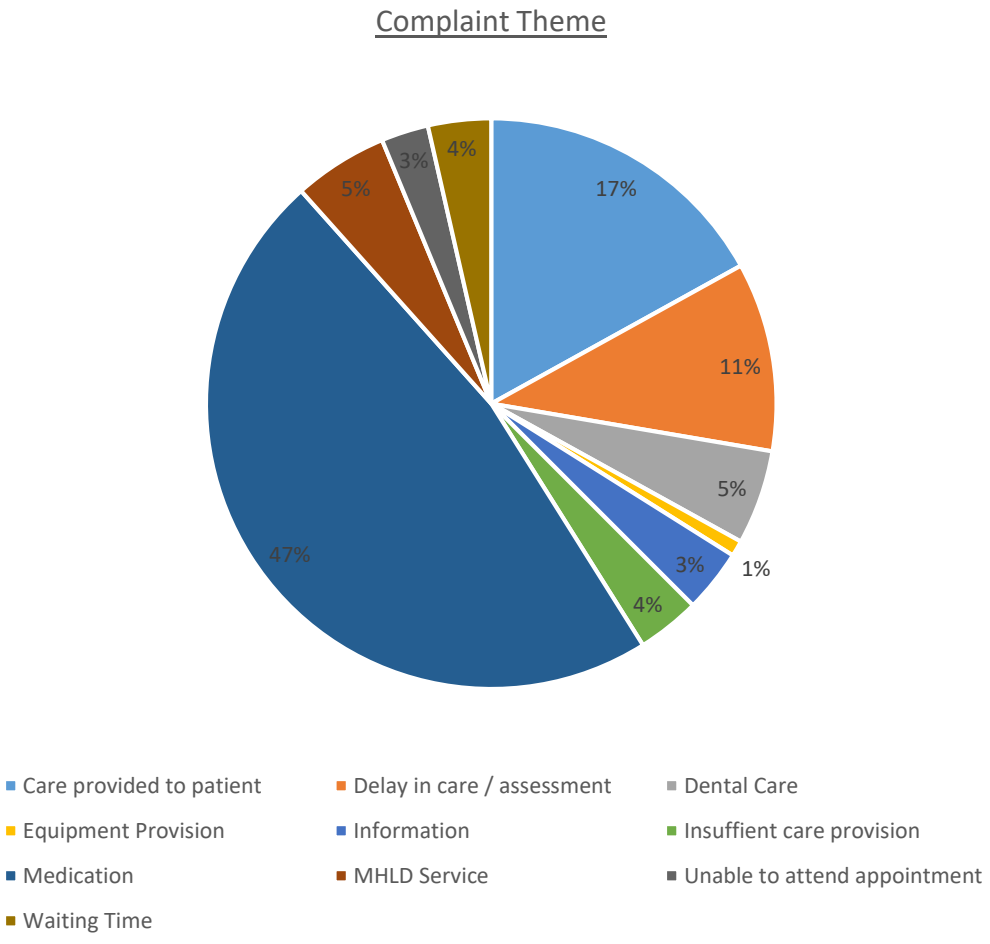
11. Health and Wellbeing Peer Mentors



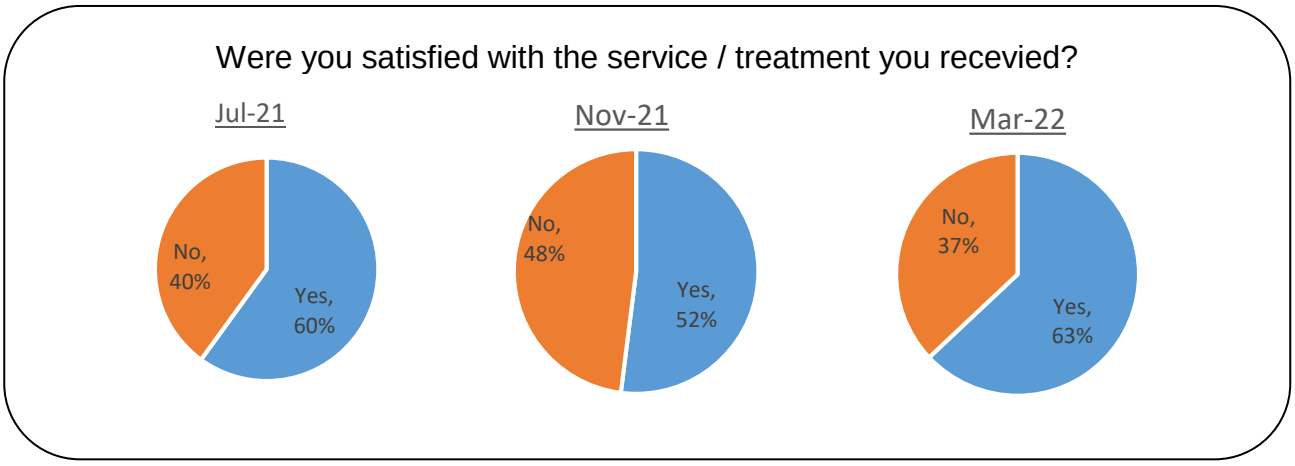


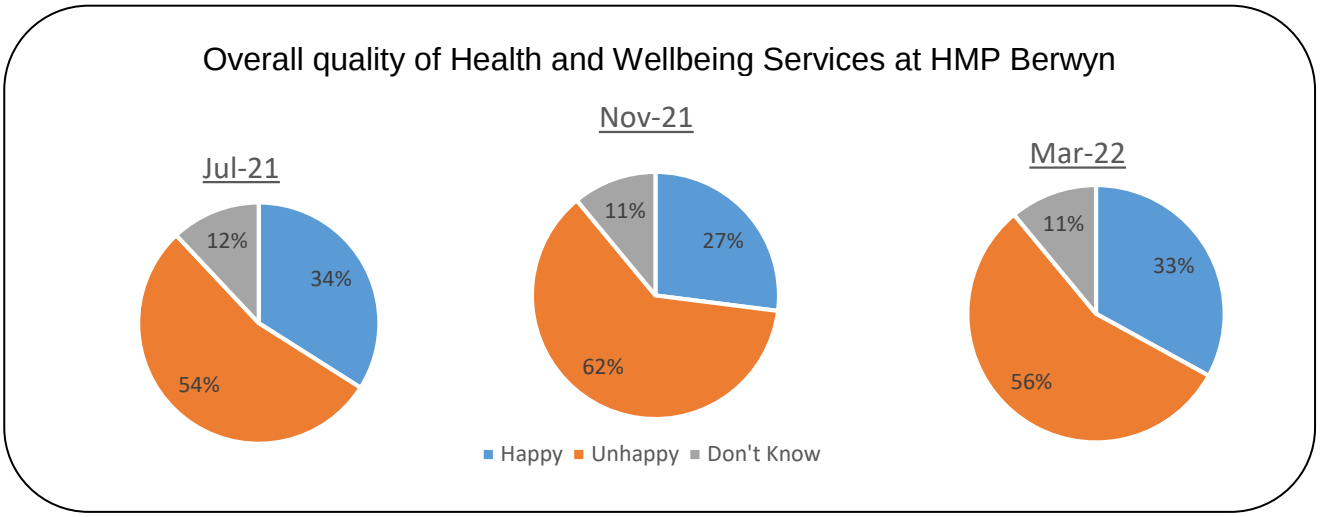
12. Complaints

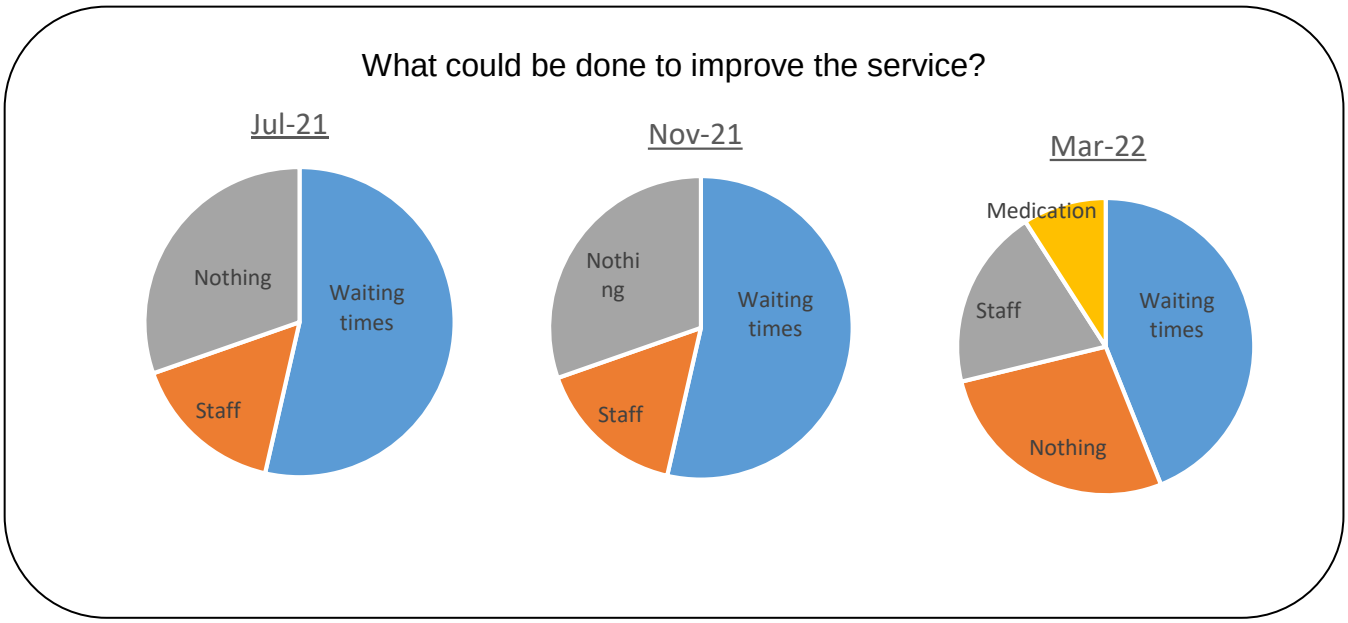




13. Patient Feedback







Report title:	Corporate Safeguarding Annual Report 2021-2022
Report to:	Quality, Safety & Experience Committee
Date of Meeting:	Tuesday, 06 September 2022
Executive Summary:	The Safeguarding and Public Protection Annual Report 2021-2022 provides assurance against performance and compliance in respect of statutory safeguarding legislation and best practice, regarding to Safeguarding Adults and Children and Young People who are at risk of harm, Violence Against Women and Sexual Violence (VAWDASV), Mental Capacity and Deprivation Liberty Safeguards and the wider Public Protection and Harm agenda. The safeguarding agenda is underpinned by legislation, policy and procedure. The role of the Safeguarding and Public Protection Team is to provide expert guidance and statutory direction to ensure the Health Board executes its responsibilities and complies with safeguarding legislation, providing assurance that strategic measures are implemented. The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of monitoring and collating NHS performance, enabling benchmarking, organisational assurance, shared practice and a drive for improvements. BCUHB has again, for the second year, achieved full compliance with this quality audit. The implementation of new legislation, and as a result of COVID-19, the service has experienced a significant rise in the level of activity and complexity, this is experienced throughout the Health Board and by our partner agencies. This reflects the National picture. The report highlights performance and activity data from the period of 01.04.2021 to 31.03.2022. This includes key achievements and assurance, and identifies areas where a targeted approach is required to ensure improvements to safeguard service users and their families.
Recommendations:	The Board is asked to note the Annual Report for the period of 2021-2022.
Executive Lead:	Gill Harris, Deputy CEO/Executive Director Of Integrated Clinical Services
Report Author:	Michelle Denwood, Director of Safeguarding and Public Protection

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

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

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Not applicable	
Link to Strategic Objective(s):	North Wales Safeguarding Adult Board North Wales Safeguarding Children Board
Regulatory and legal implications	Social Services and Wellbeing (Wales) Act 2014; Crime and Disorder Act (2014); The Human Rights Act 1998, Mental Capacity Act 2005; Mental Capacity (Amendment) Act (Wales) Act 2019 and Children Act 1989 and 2004. Domestic Abuse Act (2021)
Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)	Not applicable
Financial implications as a result of implementing the recommendations	None
Workforce implications as a result of implementing the recommendations	None
Feedback, response, and follow up summary following consultation	Clear report, evidences continued intervention, organisational challenges and the increase in activity.
Links to BAF risks: (or links to the Corporate Risk Register)	CRR21-14 CRR21-15
Reason for submission of report to confidential board (where relevant)	Not applicable
Next Steps: Implementation of recommendations	
Appendix 1 Corporate Safeguarding and Public Protection Annual Report 1st April 2021 – 31st March 2022	

QSE Committee

Tuesday, 06 September 2022
Corporate Safeguarding Annual Report 2021-2022

1. Introduction

The Social Services and Wellbeing (Wales) Act 2014 (Part 7) is the legislation governing the Safeguarding and Public Protection Agenda. Specific legislation drives the key subject areas and the wider harm agenda relating to Violence against Women Domestic Abuse and Sexual Violence (VAWDASV), Human Trafficking and Modern Day Slavery, Child Sexual Exploitation. The Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS) Code of Practice is fundamental in the overarching and targeted agenda.

The Annual Report 2021-2022 outlines the continued progress and the activities relating to Safeguarding Adults, Safeguarding Children and Young People and the wider safeguarding agenda which is driven by legislation, and best practice guidance.

The impact of the COVID-19 pandemic has seen an increase in reporting across all areas evidencing an upward trend. BCUHB have seen a 400% increase in the reported activities relating to Domestic Abuse (DA) incidents in the last 12 months. This is in line with the national position. The numbers alone do not reflect the demand on our services or front line services due to the complexity, severity and the recognised risk to life relating to each incident.

In addition, the Public Protection agenda has seen a meteoric rise in activity legislated by the Crime and Disorder Act 2015. Public Protection activity relating to Modern Day Slavery, Human Trafficking, County Lines, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), and Terrorism has required an increase in operational and multi-agency activities over the last 12 months.

To provide assurance and compliance the annual report provides evidence of strategic activity and safe care and practice. Safeguarding is everyone’s business and the Health Board has a legal duty to fully engage, comply and report the organisations position to the Welsh Government.

To evidence compliance and to support the implementation of the agenda, the Corporate Safeguarding and Public Protection Team continues to use the five (5) key standards of the National Safeguarding Maturity Matrix (SMM), to quality assure activities and to benchmark compliance against other NHS organisations. The tool supports the collation of evidence and provides assurance which equally supports future and ongoing improvements.

2. Key Performance Activities

The Safeguarding and Public Protection Team have continued to embed National and Regional Strategic Plans into practice to identify, reduce and safeguard service users, their families and BCUHB employees, with a particular emphasis upon high risk and targeted services across the organisation. Performance is benchmarked against local, regional and national safeguarding and public protection performance indicators. This evidence supports targeted intervention to improve standards and increased safety.

2.1 Quality and Governance Framework

The National NHS Safeguarding Maturity Matrix is a quality framework which supports our evidence against our compliance with legislation, best practice and innovative preventative work and enables BCUHB to benchmark against other NHS organisations in Wales. The Safeguarding Maturity Matrix self-assessment of Safeguarding arrangements was undertaken by all NHS organisations in Wales. A Governance and Rights-Based Approach, Safe Care, Adverse Childhood Experiences (ACE) Informed, Learning Culture, and Multi Agency Partnership Working are the five (5) standards evaluated. The highest possible score for each criterion is five (5), for a total score of twenty-five (25).

2.2 Safeguarding Maturity Matrix Score

BCUHB achieved a score of 25:25 as shown in Table 1 below:-

Table 1

Dates	Score	Trend
2018 - 2019	14	
2019 - 2020	23	
2020 - 2021	25	
2021 - 2022	25	

Action
With the exception of the Mental Health & Learning Disabilities (MHLD) Safeguarding Forum, a key challenge is to improve the ownership and leadership of operational Safeguarding Forums which have seen a decrease in activity and engagement.

The risk as a result of this is;

- Non-compliance with the Safeguarding Governance and Reporting Framework.
- Reduces the identification of risk and proactive safeguards.

To improve this position internal escalation and structured meetings have taken place with the identified Chairs and we have seen an improved position. However, due to the 'New Operating Model' a review of the Safeguarding Reporting Framework is required, with a review of the Terms of Reference for all Safeguarding Forums and the Safeguarding Governance and Performance Group.

2.3 Reporting Data

The COVID-19 pandemic has seen a significant increase in activity and complexity relating to the identification and reporting of abuse and harm. This is in line with the National NHS picture and for our partner agencies. The key areas evidenced are;

2.3.1 Adult at Risk Reporting Data

In 2021-2022, the Corporate Safeguarding Team received 1407 Adult at Risk Reports from across BCUHB services. This is a 9.6% increase against the 2020-2021 position.

Table 2

Year	Reports	
2020-2021	1284	
2021-2022	1407	

Table 3

Year	West	Central	East	Out of Area	Total
2020-2021	463	358	444	19	1284
2021-2022	402	435	517	53	1407
% Change	↓ 13.2%	↑ 21.5%	↑ 16.4%	↑ 178.9%	↑ 9.6%

The increase in safeguarding support, responsive supervision and training for staff is believed to have contributed to the improved identification of risk and harm.

The continued implementation of the Wales Safeguarding Procedures (2019), and the introduction of the new statutory role of the Designated Safeguarding Person (DSP) and Enquiries Lead (EL), and the implementation of further Safeguarding Ambassadors have contribute to a greater informed workforce.

2.3.2 Child at Risk Reporting Data

During 2021-2022 the Corporate Safeguarding Team received 3,642 Child at Risk Reports. This is a significant increase of 17% when compared to 2020-2021.

Table 4

Year	Reports
2020-2021	3116
2021-2022	3642

Table 5

Year	West	Central	East	Out of Area	Total
2020-2021	527	815	1711	63	3116
2021-2022	596	1059	1928	59	3642
% Change	↑ 13.1%	↑29.9%	↑ 12.7%	↓ 6.3%	↑ 17%

The increased reporting rates may be attributed to the reduction of COVID-19 restrictions making children more visible to services.

The identified lockdown periods clearly identify the decrease and increase in formal reporting. The impact of a recognised period of reduced visibility appears to have had an impact upon the complexity and severity of the harm reported. This results in the requirement for enhanced and sustained multi-agency intervention and engagement.

2.4 Single Unified Safeguarding Review (SUSR)

The criteria for the multiagency reviews are laid down in the Safeguarding Boards Functions and Procedures (Wales) Regulations 2015.

The purpose is to promote a positive culture of multiagency learning, for which Safeguarding Boards and Partner agencies hold statutory responsibility.

Our current position evidencing our participation and engagement regarding Adult Practice Reviews (APR's), Child Practice Reviews (CPR's), Domestic Homicide Reviews (DHR's) and Multi Agency Professional Forums (MAPF's) are shown in Table 6 below;

Table 6

Review Type	Current up to 31.3.2022			New			Total
	East	West	Central	East	West	Central	
Adult Practice Reviews	2	0	0	2	0	0	4
Child Practice Reviews	3	0	2	2	0	1	8
Extended Child Practice Reviews	1	0	0	0	0	0	1
Domestic Homicide Reviews	1	4	0	0	0	1	6
Multi Agency Professional Forums	0	0	1	0	0	0	1

During this period, a national review of the governance and reporting of future reviews is taking place. The objective is to have National data, improved learning and the identification of themes and trends using a National data tool to inform national and local learning and ultimately improve safeguards.

Mental Health Homicide reviews will also be included within this process which will ensure a full system approach, reduce duplication and reduce delay. Most importantly the reviews will reduce the reintroduction of trauma for families who have experienced the sad death or significant harm caused to a family member.

The recognised frustration with the review of Child and Adult deaths currently is the continued recognition of the same missed opportunities or omissions and the lack of National interventions from the findings.

The key themes for North Wales is the reduced compliance with safeguarding training, self-neglect and the lack of an identified Care Coordinator. Communication and documentation are also a consistent findings.

All recommendations and learning relating to the Health Board are implemented and monitored in line with the Safeguarding Governance and Reporting Framework, with oversight from the North Wales Safeguarding Boards, Welsh Government and the Home Office.

2.5 Mental Capacity 'Amendment' Act 2019 and the Liberty Protection Safeguards

On the 17th of March 2022, the Welsh Government published the consultation on the Liberty Protection Safeguards (LPS) draft Regulations for Wales. Liberty Protection Safeguards will replace the Deprivation of Liberty Safeguards (DoLS) for all patients who need to be deprived of their liberty. Deprivation of Liberty Safeguards will continue as a process until all applications cease within the timeframe they are granted and will be replaced with a Liberty Protection Safeguards authorisation if that remains necessary. The first year of implementation will see the two processes work side by side.

BCUHB is fully engaged in the preparation and engagement for the implementation of Liberty Protection Safeguards which has implications financially, strategically and operationally. There are significant risks in managing the transition from Deprivation of Liberty Safeguards to Liberty Protection Safeguards, these are;

- New governance framework.
- The required expertise of the new legislation.
- Implementation and development of new Policy and Process.
- Implementation of the Mental Capacity Act at the front door.
- Education and Training for all BCUHB clinical staff groups.
- Increase in activity and Court of Protection activity.
- Enhanced scrutiny by Central and Welsh Government.

2.5.1 Deprivation of Liberty Safeguards (DoLS)

Like all NHS organisations, the significant increase in applications, legal challenge and Court of Protection activity has been seen by BCUHB.

The table below reports a 40% increase in applications for this period. This does not evidence the required resource and commitment to fulfill this legal requirement, which is fundamental to patient safety and experience.

Table 7

Urgent Applications (1 - 7 days)	20
Extended Applications (8 - 14 days)	24
Standard Authorisation (approved)	50
Allocated to Best Interest Assessor	14
Allocated to Section 12 (2) doctors	14
Applications under Scrutiny	7
Waiting to be Authorised	6
Backlog	36
Total	171

Welsh Government have recognised this increase in activity and they have acknowledged the delay in the receipt of the revised guidance has been challenging for all organisations.

To support the recognised challenges relating to Deprivation of Liberty Safeguards and the required organisational preparation for the new legislation, interim and non-recurring monies have been made available through funding streams.

We have continued to meet and fully engage with the Welsh Government funding process and monies are available to support interim arrangements.

The injection of additional funding is currently reporting and evidencing an improved training compliance with Mental Capacity Act training and Deprivation of Liberty Safeguards activity. This position will be reported to the Mental Health Capacity and Compliance Committee (MHCCC) in line with the reporting cycle for 2022-2023.

2.6 New legislation

2.6.1 Children (Abolition of Defence of Reasonable Punishment) (Wales) Act (2020)

The legislation gained Royal Assent and became an Act on the 20th of March 2020. The Act was implemented on the 21st of March 2022. This Act removes the defence of reasonable punishment if cases reach Court. Full implementation was achieved within the timeline. Currently this has not had an impact upon activities.

2.6.2 Domestic Abuse Act (2021)

The Domestic Abuse Act (2021) will recognise children as victims in their own right. The Act will recognise a child who sees, hears, or experiences the effects of, Domestic Abuse and who is related to the person being abused or the perpetrator as a victim of Domestic Abuse. Most of the provisions in the act will come into force during the period 2021-2022.

A strategic approach is in place to ensure the full implementation of the legislation throughout the organisation.

It is expected to increase safeguarding activity and reporting relating to both Children and Adults. This is recognised by all NHS organisations and partner agencies.

2.7 Training and Development

Targeted intervention and bespoke training packages are in place to increase awareness to support the prevention and identification of abuse and harm.

A success for this period is the development of additional training materials for the Estates Team, which has resulted in an improved position of 53.5% compliance against a position of 43.3% mandatory training compliance for the period 2020-2021.

New materials are continuously under development to ensure the training agenda meets the needs of front line clinical teams, and implements the Safeguarding and Public Protection agenda. Training data and the analysis of compliance is reported and escalated by the Safeguarding Reporting Framework and areas target to support improvement and compliance.

We continue to have areas and departments in which we are targeting to support and improve the training compliance and the application of learning.

Again, for the period of 2022–2023 as a result of the end of year training compliance we continue to target key General Practitioner (GP) practices and Emergency Departments as a priority.

Table 8 Emergency Department Violence Against Women Domestic Abuse Sexual Violence Training Compliance

Compliance Reported ESR	Staff	2020-2021	2021-2022	Trend	Update Position July 2022
YG Medical	52	40.0%	46.2%	↑	53.7%
YG Nursing	69	87.0%	73.9%	↓	71.6%
YGC Medical	39	45.0%	38.5%	↓	38.2%
YGC Nursing	96	79.0%	63.5%	↓	58.9%

WMH Medical	36	38.0%	47.2%	↑	50%
WMH Nursing	108	85.0%	71.3%	↓	72.4%

We fully engage and respond to new legislation, learning from reviews, investigations and both National and Regional enquiries.

To ensure quality and enhanced safeguards are in place we always benchmark against our current practice and findings are implemented and audited to provide assurance.

As a result we have implemented and are currently reviewing compliance against the Cardiff and Vale University Health Board recommendation of the review of incidents relating to young children who have sustained injuries and attended Emergency Departments for treatment.

2.8 Evidence of improved safeguards

Patient A is a 74-year-old lady with an established diagnosis of Learning Disability and a history of multiple cerebrovascular accidents (Stroke) leading to both physical and mental health consequences.

Patient A was admitted into an acute hospital after repeated vomiting leading to aspiration and chest sepsis. A Deprivation of Liberty Safeguards (DoLS) application was submitted, and an assessment was undertaken. The Deprivation of Liberty Safeguards (DoLS) was authorised to ensure Patient A was accommodated under a legal framework.

To facilitate a safe discharge Patient A required a package of care. This was not in place and a best interest decision was made for Patient A to remain in hospital to ensure her needs were being fully met in a safe environment.

2.9 Case Learning

There was a delay in the Deprivation of Liberty Safeguards Authorisation being granted resulting in an unlawful deprivation. The case highlighted the lack of resources within the current Deprivation of Liberty Safeguards service and the potential for Patient A to have made an application to the Court or Protection and be awarded damages due to the delay in authorisation.

2.10 Assessment and Analysis

- Improved awareness due to an increase in training compliance.
- Improved recognition by front line staff of the Mental Capacity Act (MCA).
- The delay in Deprivation of Liberty Safeguards authorisation is a national issue.

2.11 Action

- A targeted approach was implemented, supported by enhanced administration, which included daily telephone calls to each ward where a Deprivation of Liberty

Safeguards application was in place, to challenge the position and support any change.

- Amendment to working practice and the delivery of services, from five (5) days to seven (7) days a week was implemented for a period of 6 months.
- Bespoke training events and additional Mental Capacity Act Training packages were developed.
- The development of easy read Standard Operating Procedures.
- Welsh Government recognise the challenges for NHS organisations, which has resulted in the availability of time limited funding.
- We have reported a significantly improved position with a reduced 'backlog' of Deprivation of Liberty Safeguards applications. From a reported position of one hundred fourteen (114) applications, to a reported position of thirty-six (36) applications by March 31st 2022.
- As a result of ongoing audit activities and by comparing the results of the same audit in 2020-2021 we can report an improved position and understanding of the Deprivation of Liberty Safeguards process and the implications for the service user by front line clinical teams.

2.12 Trauma Risk Management (TRiM)

Trauma Risk Management is a peer-led process that seeks to identify and assess the psychological risk to individuals who have experienced trauma in the course of their work.

Early identification of staff exposed to trauma, aids to promote a healthy workforce, by supporting the welfare needs of staff, and contributes towards reducing staff absence.

Following the introduction of Trauma Risk Management by the Safeguarding and Public Protection Team in May 2020 there have been seventy (70) incidents within BCUHB that have been referred to the Team for support and action. During the period of 2021-2022 there were forty-one (41) referrals submitted.

2.13 Assessment and Analysis

The themes for the referrals include assaults/verbal abuse of staff by patients, death of patients including children, medical emergencies and maternal deaths. Of the forty-one (41) cases referred, seventeen (17) had no further action. The rationale for no further actions has been due to the referrals being received outside of the timescales and best practice guidance acknowledges there is a risk of re-traumatising staff members. There were also some referrals deemed inappropriate in terms of not meeting the threshold for Trauma Risk Management and staff who were not employed by BCUHB.

2.14 Impact on Staff

The evaluation forms highlight that staff have found the process helpful, supportive and beneficial. Examples of qualitative findings included:

"I think it is an excellent service and I have never felt as supported in my career as I do now, value the quick response time from incident to assessment, my feelings were listened too, benefitted me have time and space away from the office to discuss my feelings to an independent practitioner".

There are currently twenty-two (22) Trauma Risk Management Practitioners across the Health Board including four (4) Trauma Risk Management managers. Some of the training was supported by Awyr Las funding.

2.15 Conclusion

The detailed report evidences the substantial and progressive activities taken to provide assurance of compliance with legislation and the wider safeguarding strategic agenda.

Strengthening the team structure is seen as a paramount requirement to continue to implement new legislation and respond to an increase in activity and complexity. The risks are recorded and monitored by the Risk Management Group

The safeguarding strategy ensures a person centered, rights based approach with targeted intervention and prevention, which is lawful and consistent and will result in increased patient safety and experience, and a reduction in harm and financial and/or reputational damage. There is clear and continuous evidence of learning and improvement, with targeted activities to improve our safeguards.

The strategic priorities for 2022-2023 demonstrate our dedication to improvement on a continuous basis to safeguard our service users and families, employees, and the Health Board.

3. Budgetary / Financial Implications

3.1 There are no budgetary implications associated with this paper.

4. Risk Management

4.1 CRR21-14 - **Risk: -** There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients.

4.2 CRR21-15 – **Risk: -** There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Wellbeing (Wales) Act 2014.

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 and 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.

5. Equality and Diversity Implications

All Policies, Procedures, documentation, and safeguarding activity that impacts upon patients, staff or the organisation are in line with a supporting Equality Impact Assessment (EqIA). Consultation and engagement takes place with both internal and where appropriate external stakeholders.

Appendix 1

Corporate Safeguarding and Public Protection

Annual Report

1st April 2021 – 31st March 2022

Contents Page

Appendices

The following Appendices are including within the report as supplementary material which will provide a more comprehensive understanding of the information:-

i. Appendix 1
BCUHB Corporate Safeguarding Team Safeguarding Adults Annual Report 2021-2022

ii. Appendix 2
BCUHB Corporate Safeguarding Team Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Annual Report 2021-2022

iii. Appendix 3
BCUHB Corporate Safeguarding Team Deprivation of Liberty Safeguards, Mental Capacity Act, and Liberty Protection Safeguards Annual Report 2021–2022

Foreword

The Corporate Safeguarding and Public Protection Team continue to implement National and Regional Strategies and Strategic Plans to identify, reduce and safeguard service users, their families and BCUHB employees, with a particular emphasis upon high risk and targeted services across the organisation.

The Corporate Safeguarding and Public Protection Team currently works towards local, regional and national safeguarding and public protection performance indicators to evidence and improve Adult/Child at Risk of Harm, Abuse or Neglect, and Violence Against Women, Domestic Abuse, and Sexual Violence (VAWDASV) performance and compliance, resulting in improved patient and service user outcomes and the reduction of harm.

BCUHB must adhere to new and current government legislation to implement national strategies. This statutory requirement requires full engagement in the development and implementation of joint strategies with Local Authorities, Police, Probation, Public Health Wales, NHS Wales and other statutory agencies to meet the requirements of various legislative policies to safeguard and protect vulnerable persons and those at risk of harm and abuse. This includes The Social Services and Wellbeing (Wales) Act 2014, the Crime and Disorder Act 2015 and the Domestic Abuse Act 2021

In addition, the Public Protection agenda has seen a meteoric rise in activity, for example public protection activity relating to Modern Slavery, Human Trafficking, County Lines, Child Sexual Exploitation (CSE), Child Sexual Abuse (CSA), and terrorism has increased by over 400% in the last 12 months.

We would like to take this opportunity to thank our internal and external colleagues, stakeholders, and independent service users who have engaged with and supported the Safeguarding and Public Protection Team to implement the safeguarding agenda. Collaboration, engagement and contribution continues to benefit the service and inform safeguarding practice and training programmes resulting in the implementation of real change to evidence service progress throughout the organisation.

Michelle Denwood, Director of Safeguarding and Public Protection.

Progress during 2021-2022

1. Introduction

The Annual Report 2021-2022 outlines the continued evolvement of the Corporate Safeguarding Team and their work relating to Safeguarding Adults, Children and Young People, Violence Against Women, Domestic Abuse, and Sexual Violence (VAWDASV), Deprivation of Liberty Safeguards (DoLS), Dementia, and the broader safeguarding activities covered by the National harm, abuse and neglect agenda.

Deprivation of Liberty Safeguards reports directly to the Mental Health Capacity and Compliance Committee (MHCCC) and is integral to the patients' journey and clinical pathway. Currently the Corporate Safeguarding Team manages cases of patients who lack the capacity to agree to be accommodated in hospitals, hospices or an independent hospital for their care and treatment.

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

The implementation of The Social Services and Wellbeing (Wales) Act 2014 and the Wales Safeguarding Procedures 2019 has strengthened the safeguarding agenda across the organisation. Learning from and implementing safeguarding legislation has a significant impact upon the health, and wellbeing of the service user and family. A Human Rights approach is at the forefront of our practice and engagement with service users and their families. Learning from incidents and practice enables us to reinforce best practice, gain assurance and deliver a service, which reduces risk and harm.

Appendices 1-3 of this report provide detail and analysis of the substantial and progressive work made by BCUHB regarding the safeguarding agenda. There is clear and continuous evidence of learning and assurance, as well as additional measures to improve our safeguards. The strategic priorities for 2022-2023 demonstrate our dedication to improvement on a continuous basis to safeguard our patients, staff, and the Health Board.

2. Quality, Assurance and Governance

The Safeguarding Priorities set for 2021-2022 have progressed, these continue to be monitored on a quarterly basis by the Safeguarding Governance and Performance Group and the Patient Safety and Quality Group, formerly known as Quality and Safety Group.

The Safeguarding Maturity Matrix (SMM) is a quality outcome monitoring tool with the aim of capturing and collating a National Safeguarding Maturity Matrix providing assurance, shared practice, and drives improvements towards a 'Once for Wales' consistent approach to safeguarding.

In 2021-2022, BCUHB Corporate Safeguarding contributed to the All-Wales Task and Finish Group reviewing the National Safeguarding Maturity Matrix. This work was completed in principal but will be piloted in the first instance to ensure it remains fit for purpose.

The Safeguarding Maturity Matrix self-assessment of safeguarding arrangements was undertaken by each Health Board/Trust. Governance and Rights-Based Approach, Safe Care, Adverse Childhood Experiences (ACE) Informed, Learning Culture, and Multi Agency Partnership Working are the five standards evaluated. The highest possible score for each criterion is five (5), for a total score of twenty-five (25). A Peer Review of the Safeguarding Maturity Matrix was held with BCUHB being paired with the Welsh Ambulance Service Trust (WAST). This was a positive and productive event which was presented in a National Safeguarding Maturity Matrix Forum.

BCUHB achieved an initial score of fourteen (14) in 2018 but progressed to a full score of twenty-five (25) in 2020-2021 and this was maintained during 2021-2022 with evidence of further progress.

BCUHB contribute to the National picture by reporting to the Chief Nursing Officer in Welsh Government via the NHS Safeguarding Network.

3. Adult at Risk

During the first COVID–19 lockdown in March 2020 there was an initial decline in Adult at Risk Reporting. Adult Health and Social Care services recognised this was a National trend.

In 2021-2022, 1407 Adult at Risk Reports were received from across BCUHB (this includes commissioned patients by BCUHB but receive care out of county). This is a 9.6% increase when compared to the data for 2020-2021 where 1284 Reports were received.

Table 1

Year	Reports
2016-2017	986
2017-2018	1034
2018-2019	1113
2019-2020	1219
2020-2021	1284
2021-2022	1407

Table 2

Year	West	Central	East	Out of Area	Total
2020-2021	463	358	444	19	1284
2021-2022	402	435	517	53	1407
% Change	↓ 13.2%	↑ 21.5%	↑ 16.4%	↑ 178.9%	↑ 9.6%

The Safeguarding Team identified the potential risk of hidden abuse and reinforced the Adult at Risk and Safeguarding agenda during this period through enhanced communication and engagement with the workforce. Staff welcomed responsive supervision; in addition, both virtual and face to face bespoke training was safely undertaken. This training provided confidence to the staff and assurance to the Health Board that the knowledge and skills to safeguard were in place and embedded into practice.

Figure 1 - Number of Adult at Risk Reports (2021-2022) with the Welsh Government COVID-19 Lockdown periods highlighted.

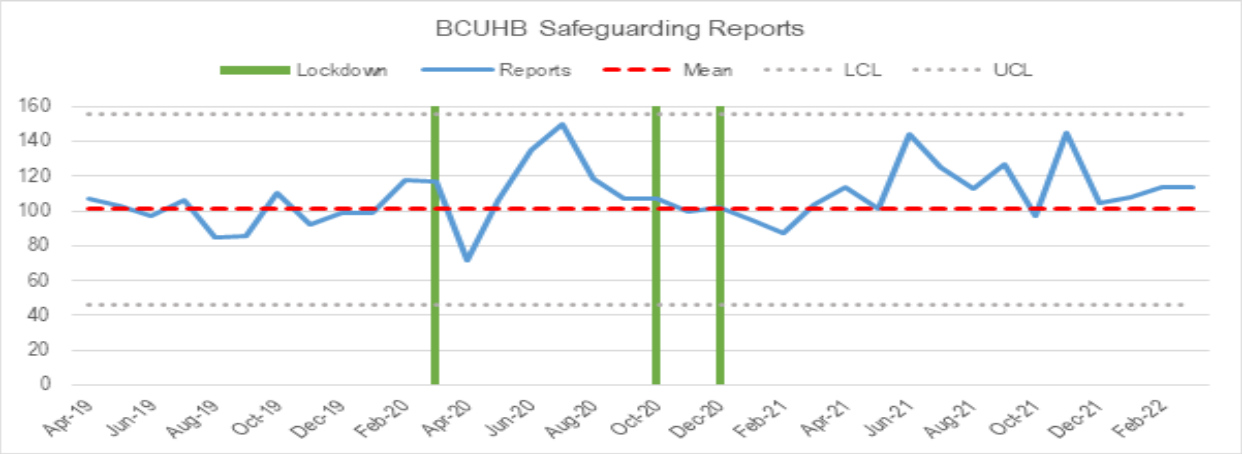


Figure 1 is a timeline that denotes the number of Adult at Risk reports by month from April 2019 – March 2022. The graph also highlights the government directed lockdown period. The chart has lower and upper control limits with a median line to depict average limit. This allows for the detection of a decrease in reporting at the start of the lockdown and a considerable increase by July 2020. The initial reduction of reporting is likely the result of the impact in reduced face to face contact with patients mostly in the community, care home or outpatient setting.

The increase and sustained upward trajectory of Adults at Risk report possibly the result in the relaxation of lockdown rules, increased face-to-face service delivery and increase in Safeguarding support.

Assessment and Analysis

The BCUHB Safeguarding Team have worked closely with community colleagues to emphasise the need to have professional curiosity and consider Safeguarding during those essential visits that are permitted during these times. An increase in Safeguarding support, responsive supervision and training for staff contributes to the improved identification of risk and harm.

3.1 Falls

During 2021-2022, there were 4882 Datix Incidents in relation to slips, trips, falls and collisions. This is a 4.3% decrease when compared to the 2020-2021. The concerns raised is the growing number of repeated falls for the same patients.

It is also noted those who have multiple incidents reported on Datix are also linked to other incidents to include pressure ulcers and/or medication error.

Assessment and Analysis

It is evident by desktop reviews, the triangulation of information and data, there is no consistent correlation between falls and adult at risk reporting. The inclusion of the Wales Safeguarding Procedures 2019 in the revised falls policy, and the inclusion of the impact of 'Falls' in safeguarding training packages reinforces the identification of a safeguarding risk. The development of co-produced training packages with Wrexham Local Authority and the inclusion of safeguarding training and 'falls' incorporated into Manual Handling training, is expected to see an improved awareness. Falls is also embedded into the Level 3 Adult Safeguarding Training.

3.2 Desktop Reviews

In 2021-2022 there has been four (4) completed Desktop Reviews under this framework. The Safeguarding Escalation Standard Operating Procedure (SOP) provides a clear process of what is required when safeguarding meets the Level 3 criteria of the SOP. A desktop review may be required to establish areas of concern to support and implement further learning through the triangulation of data. The Llandudno Hospital desktop review resulted in the quality improvement plan, which was developed with support and engagement from a North Wales Safeguarding Adult Board member, Community Health Council as well as representation from the Tawelfan Families group.

Assessment and Analysis

The reviews for 2021-2022 and the previous six (6) reviews since 2018 have identified a number of themes, these include;

- Lack of / or delay in escalation to both line managers and Corporate Safeguarding.
- Poor communication in practice and with colleagues, this includes omitting Corporate Safeguarding to the Make it Safe reviews.
- The voice of the patient has not been considered.
- Continued lack of safeguarding considerations for Adverse Discharges, Medication incidents, Pressure Ulcers and Falls, resulting with or without harm. This includes the omission of reporting safeguarding concerns on Datix.

It is important to acknowledge the good practice identified and shared across the Health Board. Staff in the reviews have engaged in the improvement plan and fully embraced the process. The plans are monitored within the area Safeguarding Forums ensuring learning is implemented across the area. This also formulates the chairs assurance report that is presented within the Safeguarding Governance and Performance Group.

3.3 Dementia

The recruitment of a Regional Safeguarding Specialist for Adults and those Adults living with Dementia has strengthen the engagement between safeguarding and the Dementia strategy, this is in line with the Health and Social Care Advisory Service (HASCAS) and Ockenden Recommendations. The priority of this post has been to support the most complex cases, where specialist knowledge and significant expertise in both Dementia Care and Safeguarding is required to ensure best practice for adults living with dementia.

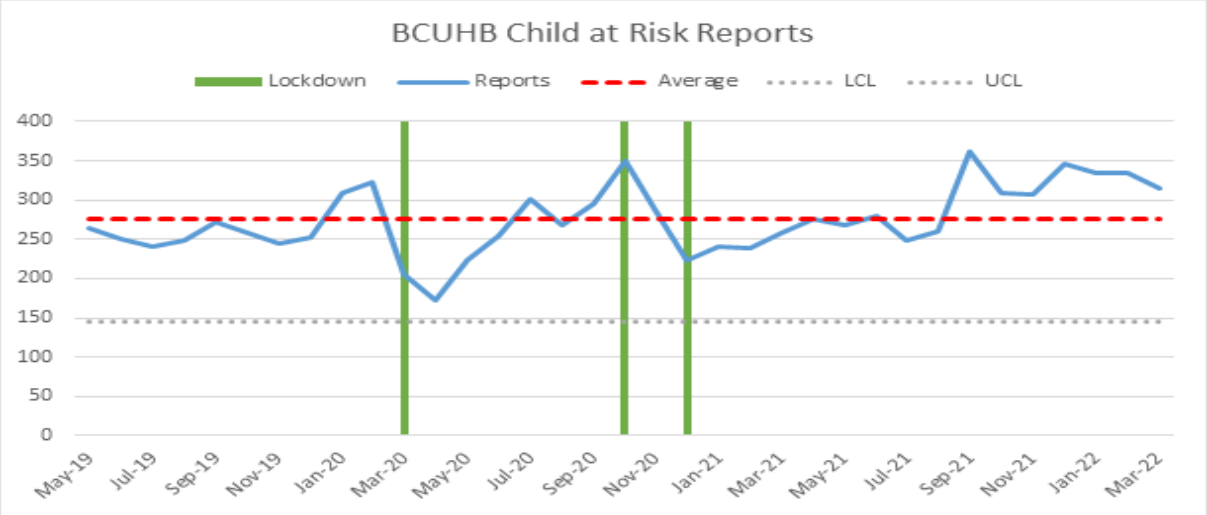
Assessment and Analysis

Dementia Care Mapping has commenced within the Older People Care settings within the Mental Health and Learning Disability (MHLD) Division which has proved positive and informative. Scoping for individuals with dementia on acute wards in district general hospitals and community hospitals has commenced and will be a priority action for 2022-2023.

4. Children at Risk

4.1 Child at Risk Reporting

Figure 2: Child at Risk Reports (May 2019 – March 2022) with the Welsh Government COVID-19 lockdowns indicated.



Assessment and Analysis

In this reporting period the Corporate Safeguarding Team received 3642 Child at Risk reports. This is a significant increase of 17% when compared to the 3116 Child at Risk reports received during 2020-2021. Although several COVID-19 restrictions have remained, within this period we have not been subject to periods of ‘lockdowns’.

This first period show more normal patterns of movement by the public with a gradual return to more face-to-face engagement with Children, Young People and their families.

In exploring, the data there are two peaks in September and December 2021.September coincides with Child and Young People returning to educational setting and having more interaction with health colleagues. December saw an increase in reports relating to the 11 year to 15 year old population, with concern relating to emotional well-being and mental health. This pattern has been previously reported by the Safeguarding Team.

A dip in reporting was observed in July and August 2021 which coincides with children and young people being absent from school for the summer holidays, this is consistent with previous patterns.

Table 3

Year	Reports	
2020-21	3116	
2021-22	3642	

Table 4

Year	West	Central	East	Out of Area	Total
2020-21	527	815	1711	63	3116
2021-22	596	1059	1928	59	3642
% Change	↑ 13.1%	↑29.9%	↑ 12.7%	↓ 6.3%	↑ 17%

The overall data indicates a gradual rise in the number of submitted Child at Risk reports.

The greatest number of reports being generated in East of region.

Table 4: **Child at Risk Reports by Designation of referrer.**

Designation of Referrer	Reports	Proportion of Reports
Emergency Dept	906	24.9%
Other	759	20.8%
Health Visitor	666	18.3%
Midwife	566	15.5%
Child Adolescent Mental Health Service (CAMHS)	423	11.6%
School Nurse	107	2.9%
General Practitioner	84	2.3%
Children's Ward	74	2%
Substance Misuse Service (SMS)	46	1.3%
Not Recorded	11	0.3%

Assessment and Analysis

Emergency Department (ED) clinical colleagues continue to submit the highest number of Child and Risk Reports. This accounting for 24.9% of all reports. This figure reflects the previous year's data in respect of Emergency Department reporting. Corporate Safeguarding continue to offer safeguarding support and advice through the hospital Liaison specialist based across the three Emergency Department sites.

The Safeguarding Team continues to deliver safeguarding training, train and support the increasing number of Safeguarding Ambassadors in Emergency Department and across the three sites, and continue to support and monitor the development and implementation of targeted safeguarding improvement plans to support Emergency Departments.

The 'other' category accounts for 20.8% and these cover a very wide spectrum of services. There is need to explore these 'other' reports to ascertain their true origin. This will be focus for the Safeguarding Audit activity throughout 2022-2023.

4.2 Safeguarding Children Training Compliance

Level 3 training compliance is reported within Level 2 and this process is managed by the training team within Workforce and Organisational Development. As a result of Level 3 not being be accurately reported at the moment, Corporate Safeguarding have added this to the risk register.

Assessment and Analysis

The East area has the highest overall compliance of the three areas.

Although the West Health Economy is showing a decrease in compliance, the reduction is minimal, and the Central Health Economy remains stable.

Training is provided on a number of IT platforms and is undertaken on Teams and Face to Face.

Packages are developed in response to incidents and national strategies and training is provided using actual learning from incidents and events.

Table 5: **March 2022 Safeguarding Training Compliance by Area and Subject**.

Area March-2022 Compliance	West	Central	East
Children – Level 1	80.1%	76.6%	81.1%
Children – Level 2	76.1%	75.1%	77.8%
Average Area Compliance	77.1%	75.8%	78.3%
Compliance Trend	↓	↔	↑

The Safeguarding Team continues to support the organisation through the Practice Development Managers to ensure a high level and flexible approach to training is delivered. The training compliance is reported and monitored at Safeguarding Forums, Department Action Plans, Risk Register and through the Safeguarding Reporting and Governance Framework.

5. Safeguarding Midwifery

5.1 Routine Enquiry Domestic Abuse (REDA) during Pregnancy

Standard two of the All-Wales Minimum Standards states that all Health Boards should complete an annual audit. The methodology for this audit was a retrospective case note audit. The table below highlights the compliance in 2021-2022.

Table 6 ***Audit compliance***

BCUHB	Audited Notes	Asked Once	Asked Twice	Not Asked at All	Mitigation – Accompanied	Mitigation – No Reason Given
Q1 2020-21	135	80%	67%	20%	12%	8%
Q2 2020-21	135	91%	73%	9%	1%	7%
Q3 2020-21	135	82%	73%	18%	1%	17%
Q4 2020-21	135	89%	80%	11%	1%	10%
Q1 2021-22	135	92%	84%	8%	0%	8%
Q2 2021-22	135	92%	81%	8%	1%	7%
Q3 2021-22	135	92%	80%	8%	1%	7%
Q4 2021-22	135	92%	78%	8%	1%	7%

Assessment and Analysis

- 92% of pregnant women were asked Routine Enquiry Domestic Abuse at least once in 2021-2022 compared to 86% in 2020-2021.
- 78% of women were asked the routine enquiry questions twice or more. This is an improvement in compliance when compared to Q3.
- 8% of the women were not asked at all. This is consistent with what has been seen in each quarter of 2021-2022.
- No reason was given as to why most women were not asked. However, it is documented that 1% of the women were not asked as they were accompanied during their appointment.

The overall improvements could be partially attributed to the restrictions in visiting during the COVID-19 pandemic. However, these restrictions were eased in September 2021 to allow a birth partner to attend antenatal appointments in the community. Overall, for women being asked twice or more, there has been a reduction by 3%, when comparing Q2 to Q4.

Compliance will continue to be closely monitored to ensure that this does not have a detrimental effect on routine enquiry.

Compliance is also being reviewed as part of the Stillbirth Reduction action plan within the women's division, following on from the thematic review in 2019.

Completing Routine Enquiry Domestic Abuse gives women an opportunity to disclose domestic abuse and referral to specialist services for support. The risks of not asking reduces this opportunity and potentially increases the risk of further abuse, harm, and death.

5.2 Routine Enquiry Domestic Abuse (REDA) within Emergency Departments

Corporate Safeguarding have engaged with each of the BCUHB Emergency Departments to support the responsiveness of the Routine Enquiry Domestic Abuse to identify those who are at risk of violence or domestic abuse. There are three (3) newly appointed Independent Domestic Violence Advisor employed funded by the Ministry of Justice; one is based in Ysbyty Gwynedd, Ysbyty Glan Clwyd and Ysbyty Maelor. The post for Ysbyty Maelor the latest appointment but they are highly skilled. These posts will be reviewed and the outcomes evaluated.

Assessment and Analysis

- Both East and West Emergency Departments have been able to record Domestic Abuse enquiries within the 'Symphony' patient electronic record system. As of 1st April 2022, the Ysbyty Glan Clwyd Emergency Departments went live with Symphony enabling a consistent measurement of sampling and auditing of Routine Enquiry Domestic Abuse across the organisation.
- IDVA will collaborate closely with hospital staff, offering expert guidance and raising awareness to encourage victims of domestic abuse to come forward
- The capacity to electronically record Domestic Abuse enquiries aids in risk detection and evaluation. Moving forward this will become a monthly audit and will be reported and monitored at the Safeguarding Forums.

5.3 Pilot project for the Independent Domestic Violence Advisor (IDVA) role in BCUHB.

- Funding has been received from the Ministry of Justice (MOJ) to pilot three hospital based Independent Domestic Violence Advisor (IDVA). These posts will be managed by the Domestic Abuse Safety Unit (DASU) and Gorwel but will sit within BCUHB Corporate Safeguarding Team.
- The role involves empowering survivors to increase their options, make positive choices/decisions, increase their confidence, safety, and recovery.
- These posts were appointed to from February 2022 with the final appointment in July 2022. The pilot will be evaluated.

5.4 Multi Agency Risk Assessment Conferences (MARAC) for Domestic Abuse Victims

Assessment and Analysis

- There have been two hundred one (201) Multi Agency Risk Assessment Conferences referrals from health, in 2021-2022 compared to 177 in 2020-2021. All three areas have seen an increase, particularly Central, where numbers have risen by 22%.
- It is widely recognised that disclosures of domestic abuse have increased since the COVID-19 pandemic and this could account for the increase that has been seen within health.
- When analysing the age and gender of the victims, 48% of the referrals were in respect of victims aged between 25 and 39 years of age. 95% of these referrals have been in relation to female victims.

- Upon reviewing the relationship of the perpetrator to the victim, 41% (n=82) record the perpetrator as current partner/husband/wife. 40% (n=80) of the referrals record the relationship of the perpetrator as ex-partner.
- 65% (n=131) of the victims have children and 30% (n=60) were pregnant at the time of the referral. The Domestic Abuse Act 2021 will see children who live in a home where domestic abuse takes place recognised as victims in their own right rather than witnesses for the first time. The Act will recognise a child who sees or hears, or experiences the effects of, domestic abuse and is related to the person being abused or the perpetrator is also to be regarded as a victim of domestic abuse.
- When considering the designation of referrer's, Health Visitors submitted the highest number of Multi Agency Risk Assessment Conferences referrals with 24% (n=48), followed by midwives 19% (n=39) and the emergency department 17%(n=35). This is a similar picture to the one in 2020-2021.

5.5 Identification and Referral to Improve Safety (IRIS)

The Identification and Referral to Improve Safety programme involves training and support for GP's to be able to identify patients affected by domestic violence and abuse and refer them to specialist services.

£20k has been received from the Ministry of Justice to support this pilot project which will be piloted in the Central area, specifically in eight (8) GP practices in South Denbighshire.

Corporate Safeguarding are involved in the Steering Group and the first cohort of training for GP's was delivered in April 2022.

5.6 ISO Standard for Sexual Abuse Referral Centres (SARC)/ Forensic Science Regulator Guidance

The Forensic Science Regulator has published supporting Guidance and Codes of Practice and Conduct to support the attainment of International Standards for Anticontamination of Sexual Assault Referral Centres (SARC) and Assessment, Collection and Recording of Forensic Science related evidence. North Wales Police have the legal entity for the review and are working in partnership with BCUHB. From February 2022 Corporate Safeguarding agreed to lead this review on behalf of BCUHB. North Wales Police have appointed a Project Manager and Strategic Lead and a Service Delivery Group has been developed. Completion of the ISO Standards is required by October 2023.

Meeting these standards is imperative for North Wales, if we do not achieve this there will be no Sexual Abuse Referral Centre in our region.

5.7 Coping with Crying Audit

Following from the Child Practice Review for Child A in Flintshire, it was recommended for BCUHB to review the Coping with Crying guideline and audit compliance with the guideline.

The audit has included midwifery, neonates, and health visiting. A task and finish group and the audit tool were developed in Q2.

The audit commenced in October 2021 for a period of 6 months with the outcome and report to be made available in Q1 of 2022-2023.

5.8 Information Sharing with Shrewsbury and Telford Hospital NHS Trust (SaTH) and The Countess of Chester Hospital (CoCH).

Approximately two hundred fifty (250) babies per year are born in the Wrexham Maelor where the mothers reside in Shropshire. Antenatal and postnatal care is provided by Shrewsbury and Telford Hospital NHS Trust midwives however the women come to Wrexham to give birth.

For The Countess of Chester Hospital, approximately three hundred fifty (350) women choose to birth there, but reside within BCUHB catchment, usually from Flintshire.

This level of activity reinforced the requirement to have a clear and formally agreed Information Sharing Pathway for the delivery of services. The pathway for Shrewsbury and Telford Hospital NHS Trust is operational and has been formally agreed within the Womens division and Corporate Safeguarding.

Initial discussions with Countess of Chester Hospital commenced during Q4 and the information sharing pathway is currently being devised and should be signed off during Q1 2022-2023.

There is a need to ensure that the information sharing pathways are robust so that women with additional vulnerabilities and safeguarding issues are brought to the attention of BCUHB in a timely way.

6. Trauma Risk Management (TRiM)

Trauma Risk Management is a peer-led process that seeks to identify and assess the psychological risk to individuals who have experienced trauma in the course of their work.

Early identification of staff exposed to trauma, aids to promote a healthy workforce, by supporting the welfare needs of staff, and contributes towards reducing staff absence.

Following the introduction of Trauma Risk Management in May 2020 to March 2022 there have been seventy (70) incidents referred to Trauma Risk Management.

There have been forty-one (41) Trauma Risk Management referrals received during 2021-2022, compared with twenty-nine (29) in 2020-2021.

Assessment and Analysis

- Of the forty-one (41) cases referred, seventeen (17) had no further action. The rationale for no further actions has been due to the referrals being received outside the timescales as indicated in the Trauma Risk Management Standard Operating Procedure. There is a risk of re-traumatising staff members if the Trauma Risk Management is not undertaken within timescales. There were also some referrals deemed inappropriate in terms of not meeting the threshold for Trauma Risk Management and staff who were not employed by BCUHB.
- Examples of qualitative findings included: *“I think it is an excellent service and I have never felt as supported in my career as I do now, value the quick response time from incident to assessment, my feelings were listened too, benefitted me have time and space away from the office to discuss my feelings to an independent practitioner”.*

- There are currently twenty-two (22) Trauma Risk Management Practitioners across the Health Board including four (4) Trauma Risk Management Managers. Some of the training was supported by Awyr Las funding.

7. Mental Capacity 'Amendment' Act 2019 and the Liberty Protection Safeguards

On the 17th of March 2022, the Welsh Government published the consultation on the Liberty Protection Safeguards (LPS) draft Regulations for Wales. Liberty Protection Safeguards will replace the Deprivation of Liberty Safeguards (DoLS) for all patients who need to be deprived of their liberty. Deprivation of Liberty Safeguards will continue as a process until all applications cease within the timeframe they are granted and will be replaced with a Liberty Protection Safeguards authorisation if that remains necessary. The first year of implementation will see the two processes work side by side.

BCUHB is fully engaged in the preparation and engagement for the implementation of Liberty Protection Safeguards which has implications financially, strategically and operationally. There are significant risks in managing the transition from Deprivation of Liberty Safeguards to Liberty Protection Safeguards, these are;

- New governance framework.
- The required expertise of the new legislation.
- Implementation and development of new Policy and Process.
- Implementation of the Mental Capacity Act at the front door.
- Education and Training for all BCUHB clinical staff groups.
- Increase in activity and Court of Protection activity.
- Enhanced scrutiny by Central and Welsh Government.

8. Deprivation of Liberty Safeguards (DoLS)

Like all NHS organisations, the significant increase in applications, legal challenge and Court of Protection activity has been seen by BCUHB.

The table below reports a 40% increase in applications for this period. This does not evidence the required resource and commitment to fulfill this legal requirement, which is fundamental to patient safety and experience.

Table 7 ***Activity data***

Urgent Applications (1 - 7 days)	20
Extended Applications (8 - 14 days)	24
Standard Authorisation (approved)	50
Allocated to Best Interest Assessor	14
Allocated to Section 12 (2) doctors	14
Applications under Scrutiny	7
Waiting to be Authorised	6
Backlog	36
Total	171

Welsh Government have recognised this increase in activity and they have acknowledged the delay in the receipt of the revised guidance has been challenging for all organisations.

To support the recognised challenges relating to Deprivation of Liberty Safeguards and the required organisational preparation for the new legislation, interim and non-recurring monies have been made available through funding streams.

We have continued to meet and fully engage with the Welsh Government funding process and monies are available to support interim arrangements.

The injection of additional funding is currently reporting and evidencing an improved training compliance with Mental Capacity Act training and Deprivation of Liberty Safeguards activity. This position will be reported to the Mental Health Capacity and Compliance Committee (MHCCC) in line with the reporting cycle for 2022-2023.

9. Corporate Safeguarding Risks

The Safeguarding Risk Register is formally monitored and reviewed at the Safeguarding Governance and Performance Group and the Risk Management Group and reported within the cycle of business following the Safeguarding Reporting Framework.

Two level 1 risk are identified, these are;

CRR21-14 - Risk: - There is a risk that the increased level of Deprivation of Liberty Safeguards activity may result in the unlawful detention of patients.

CRR21-15 – Risk: - There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Wellbeing (Wales) Act 2014.

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 and 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.

10. Conclusion

Further evidence of progress and improvement, including the review of current practices are evidenced within this report and the supporting appendices.

However, despite the efforts and good will of staff within the Safeguarding and Public Protection Team it remains the case that the current structure cannot meet the level of demand, complexity and challenges that are evidenced within governance reporting.

The identification and monitoring of the risk register is fundamental to ensure controls are in place to support the reduction of risk to the service user and to the organisation.

On the 17th of March 2022, the Welsh Government published the consultation on the Liberty Protection Safeguards (LPS) draft Regulations for Wales. The implementation of

Liberty Protection Safeguards has implications financially, strategically, and operationally for BCUHB.

The level of specialist support for front line practitioners has been evidenced throughout this period. The challenges for the workforce impacts upon their safeguarding resilience and the need for immediate guidance and direction. The complexity and challenges are not evidenced in data, data itself is a snap shot and alone does not provide assurance.

Audit activities are key to evidence an improved position but by incorporating desk top reviews we are able to triangulate the evidence and gain assurance regarding understanding and learning.

Strengthening the safeguarding resource and ultimately the team, is seen as paramount to be able to continue to implement legislation and best practice throughout the organisation. Our aim is to provide a funded out of hours service, ensuring a person centered and preventative approach to safeguarding which is lawful and consistent and results in increased patient safety and a reduction of risk and financial or reputational damage.

With clear leadership and a strong focus on key priorities during 2022-2023 we will ensure that BCUHB's improved trajectory continues and is integrated in clinical practice.

Corporate Safeguarding Action Plan 2022-2023

Actions Log 2022-2023

Red	Incomplete
Amber	Partially complete
Green	Complete

Priority	Action	By Who:	By When:	RAG Status
Safeguarding Adults				
1	Roll out of the Enquiries Lead role across all areas of BCUHB as outlined in the Wales Safeguarding Procedures 2019.	Heads of Safeguarding Adults	March 2023	
2	Successful recruitment of all vacant posts within Corporate Safeguarding and consideration of the wider structure.	Heads of Safeguarding Adults	December 2022	
3	Action to work with WOD, Information Governance, NWP and Safeguarding in relation to agree template for reporting.	Heads of Safeguarding Adults	October 2022	
4	On recruitment of the Regional Safeguarding Adult/ Dementia Lead, commence mapping and scoping of patients within acute and community services.	Head of Safeguarding Adult / Regional Safeguarding Specialist Adult/Dementia	March 2023	
5	The Regional Adult/Dementia Safeguarding Specialist to continue to support the full implementation of All Wales Dementia Care Pathway of Standards into practice within BCUHB services.	Heads of Safeguarding Adults / Regional Safeguarding	December 2022	

		Specialist Adult/Dementia		
6	The Regional Adult/Dementia Safeguarding Specialist to explore the application of an observation tool within the district general hospital wards to provide assurance of person-centred care and wellbeing of individuals living with dementia at that time on Acute general Hospital wards.	Head of Safeguarding Adult / Regional Safeguarding Specialist Adult/Dementia	December 2022	
7	Scoping for service safeguarding needs along with under and over reporting of incidences for those individuals living with dementia receiving care on our general wards, community hospital and primary care.	Heads of Safeguarding Adults / Regional Safeguarding Specialist Adult/Dementia	December 2022	
8	To benchmark against relevant All Wales Dementia care pathway of standards in relation to ward/ service accreditation.	Head of Safeguarding Adult / Regional Safeguarding Specialist Adult/Dementia	March 2023	
9	To support the implementation of the Dementia friendly Hospital Charter.	Head of Safeguarding Adult / Regional Safeguarding Specialist Adult/Dementia	March 2023	
10	To support the Sexual Safety Group with training and evaluation of the co-produced MHLD guidance for patients and staff.	Head of Safeguarding Adult MHLD / Regional Safeguarding Specialist Adult/Dementia	September 2022	

11	To support the development and implementation of the Quality Assurance Framework for commissioned services, embedding Wales Safeguarding procedures into the programme.	Heads of Safeguarding Adults	November 2022	
12	Continue to explore ways of improving Mandatory training compliance within the Emergency Departments (E.Ds.') of BCUHB to be assured that the staff have the knowledge and skills to address presenting safeguarding concerns appropriately.	Head of Safeguarding Adults /Area Safeguarding Managers	December 2022	
13	Task and Finish Group to develop a streamlined appropriate Safeguarding reporting direct from Symphony.	Head of Safeguarding Adults /Area Safeguarding Managers	December 2022	
14	Support in the audit of compliance with Routine Enquiry Domestic Abuse within all Emergency Departments and Minor Injuries Unit.	Head of Safeguarding Adults /Area Safeguarding Managers	March 2023	
15	Corporate Safeguarding team to support Primary Care Directors to update their action plans outlining how they will address poor compliance within the identified Practices within this report.	Heads of Safeguarding and PD Leads	March 2023	
16	Corporate Safeguarding to continue to support and mentor BCUHB staff who are Reviewers and Panel Members to include sharing key themes from the reviews and producing 7-minute briefings to share for learning across BCUHB Safeguarding Forums and Governance meetings alike.	Heads of Safeguarding	March 2023	
17	Concise thematic review into completed desktop reviews and outcome to be shared widely in Safeguarding forums and supervision.	Heads of Safeguarding Adults /Area Safeguarding Managers	COMPLETED	

18	Undertake Desktop Reviews as required in line with the Safeguarding Escalation SOP. Learning from internal reviews to be shared at Safeguarding Forums both Area and MHLD.	Head of Safeguarding Adults /Area Safeguarding Managers	COMPLETED	
19	Relaunch our active offer of individual safeguarding supervision, along with group supervision.	Heads of Safeguarding Adults /Area Safeguarding Managers	September 2022	
20	Corporate Safeguarding to promote and provide further training to recruit up by 25% further Safeguarding Ambassadors for BCUHB.	Heads of Safeguarding Adults /Area Safeguarding Managers	March 2023	
21	Coordinate Quarterly Safeguarding Supervision with PALS team and embed learning from patient stories into Safeguarding Bulletin and 7-minute briefings so as this can be shared widely.	Heads of Safeguarding Adult MHLD / Regional Safeguarding Specialist Adult/Dementia	September 2022	
Safeguarding Children at Risk,				
22a	Conduct a larger scale regional retrospective audit of the quality of Child at Risk Reports Q3 & Q4.	Head of Safeguarding Children	March 2023	
22b	Quarterly Audit of Child at Risk Reports and findings report/action plan 2022-2023.	Head of Safeguarding Children	April 2023 Final Report	
23	Continued engagement in the Identification and Referral to Improve Safety Project in 2022-2023.	Head of Safeguarding Children	March 2023	

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)				
24	Continued engagement in the Independent Domestic Violence Advisor Project in 2022-2023.	Head of Safeguarding VAWDASV/Midwifery	March 2023	
25	Implement the All-Wales Minimum Standards into Domestic Abuse across all relevant areas in BCUHB.	Head of Safeguarding VAWDASV/Midwifery	COMPLETED	
26	Continue engagement and support with the ISO Standards.	Head of Safeguarding VAWDASV/Midwifery	March 2023	
27	Implementation of the updated All-Wales Female Genital Mutilation Clinical Pathway across BCUHB.	Head of Safeguarding VAWDASV/Midwifery	COMPLETED	
Safeguarding Midwifery				
28	Women's Division to lead, with support/engagement from the Safeguarding Midwives, on an audit of compliance with Routine Enquiry Domestic Abuse.	Head of Safeguarding VAWDASV/Midwifery	March 2023	
29	Midwifery Safeguarding Lead to undertake a review of the current model of the delivery of safeguarding supervision to midwives.	Head of Safeguarding VAWDASV/Midwifery	September 2022	
30	Information Sharing Pathway for BCUHB and The Countess of Chester Hospital to be devised and agreed.	Head of Safeguarding VAWDASV/Midwifery	December 2022	
31	Increase Safeguarding Ambassadors within the maternity settings.	Head of Safeguarding VAWDASV/Midwifery	March 2023	
32a	Working closely with the North Wales Reflect service, devise a training package for midwives to support and strengthen practice in the area of separation of babies from their mothers/parents.	Head of Safeguarding VAWDASV/Midwifery	March 2023	

32b	Working closely with women's services, scope opportunities to implement a 'memory box' for women who are involved in court proceedings.	Head of Safeguarding VAWDASV/Midwifery	March 2023	
MCA/DoLS/LPS				
33	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, **Mental Capacity Act 2005)** and code of practice relating to the LPS.	Heads of Safeguarding Adults	COMPLETED	
34	Implementation of the Safeguarding Business Case to support service delivery and provide a 7-day service	Heads of Safeguarding Adults	August 2022	
35	Review training compliance to ensure accuracy and target training data is on ESR.	Heads of Safeguarding Adults	June 2022	
36	Ratify and monitor the implementation of the strengthened CoP and S21A Appeal process.	Heads of Safeguarding Adults	COMPLETED	
37	DoLS Documentation Audit	Heads of Safeguarding Adults	May 2022	
38	Confirm and engage with the BCUHB Mental Capacity Act Lead	Heads of Safeguarding Adults	COMPLETED	
39	Complete actions and objectives in relation to Welsh Government funding	Heads of Safeguarding Adults	COMPLETED	
40	Engagement in Welsh Government MCA/LPS Consultation Programme	Heads of Safeguarding Adults	August 2022	

Appendix 1

Corporate Safeguarding Annual Report - Adults 2021-2022

1. Introduction

1.1 This report gives an overview of all Adult Safeguarding performance statistics held by Betsi Cadwaladr University Health Board (BCUHB)'s Corporate Safeguarding Team for the months of April 2021 to March 2022. It also shows how far the activities and priority initiatives indicated in the Corporate Safeguarding Annual Report for 2020-2021 have progressed.

1.2 The report contains information gleaned via learning and assurance in accordance with the 24 Strategic Priorities.

1.3 Evidence of change and impact on Safeguarding service delivery is clearly outlined within the main body of this report. This reflects the dynamic requirements of services during the COVID-19 pandemic to safeguard all patients, staff, and the organisation.

1.4 Although the COVID-19 pandemic continues to pose significant challenges to service provision there are notable achievements that have been made during this reporting timeframe. The achievements made are celebrated within the organisation.

1.5 This report's structure is based on the five (5) core aspects of the National Safeguarding Maturity Matrix (SMM).

1.6 The five (5) key elements of the Safeguarding Maturity Matrix reporting structure includes:

- Governance and Rights Based Approach.
- Safe Care.
- ACE informed.
- Learning Culture.
- Multi Agency Partnership Working.

1.7 Safeguarding Maturity Matrix is a quality outcome-monitoring tool designed to offer assurance, discuss best practices, and learn what is needed to implement safe and high-quality standards. This is in support of the upcoming 'Once for Wales' Safeguarding module, which will be implemented in 2021-2022.

1.8 For each element of the matrix the highest achievable score is five (5). BCUHB have been able to achieve the maximum score of 25 is achieved for 2020 and 2021 and this has been sustained through 2021-2022 thus evidencing the ability of BCUHB to maintain its improvements for each of the elements and their respective indicators.

1.9 The NHS Safeguarding Network, who reports to the Chief Nursing Officer for Wales at Welsh Government is provided with a collective report compiled by health boards and Trusts across Wales in relation to the SMM self-assessment.

2. Governance and Rights Based Approach

Rationale

2.1 It is an organisational requirement to have a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of adults at risk of abuse and neglect.

2.2 Adults at Risk – Performance and Activity

2.2.1 In 2021-2022, the Corporate Safeguarding Team have received 1407 Adult at Risk Reports from across BCUHB (this includes commissioned patients by BCUHB but receive care out of county). This is a 9.6% increase when compared to the data for 2020-2021 where 1284 Reports were received.

2.2.2 The activity from each of the areas within BCUHB is illustrated in Table 1. It identifies that Central and East saw an increase in adult at risk reporting and a reduction from the West area which continues the trend from 2020-2021. The initial increased reporting from the East attributed to increased activity and a change in service specific to Older People Mental Health within the MHLD Division. The safeguarding activity has been maintained despite the return of purpose of the inpatient provision within the East area MHLD Division. It is noted that across the East MHLD Division there has been a reduction in adult at risk reports. Within the Central area, an increase in safeguarding concerns and activity are associated to Care Homes contributing to the increase in adult at risk reports throughout the 2021-2022 period.

Table 1: Adult at Risk reports by Area 2021-2022.

Year	West	Central	East	Out of Area	Total
2020-21	463	358	444	19	1284
2021-22	402	435	517	53	1407
% Change	**↓ 13.2%**	**↑ 21.5%**	**↑ 16.4%**	**↑ 178.9%**	**↑ 9.6%**

2.2.3 In 2021-2022, 29% of reports came from the West, 31% from Central and 37% from the East. Both the Central and East areas have seen an increase when compared to last year's data and the West area has seen a decrease. The local authority with the most Adult At Risk reports during 2021-2022 is Wrexham (n=316). The Corporate Safeguarding team will explore this trend further within 2022-2023 as the number of reports alone does not directly correlate to an increase in safeguarding activity within the area.

It is however accepted that adult at risk reports do require the Designated Safeguarding Person to provide support to the staff and service that are involved in reducing the risks and or harm experienced by the individual/s who are subject to the reports.

2.2.4 The data from 2020 to this point could be viewed as an anomaly due to the COVID-19 Pandemic.

However, with a longitudinal view there has been an upward trend in Adult at Risk reports since 2017 as can be seen in Table 2 below. There is a myriad of potential causative factors to the upward trend, for example the implementation of the All Wales Safeguarding Procedures 2019, which has further increased staff awareness. Further rationale may be the continued presence and activity from the Corporate Safeguarding team in local and regional team meetings. This trend could also be aligned to the progression of the integration of Safeguarding Supervision into practice and the continuation of the Safeguarding Ambassadors programme for staff.

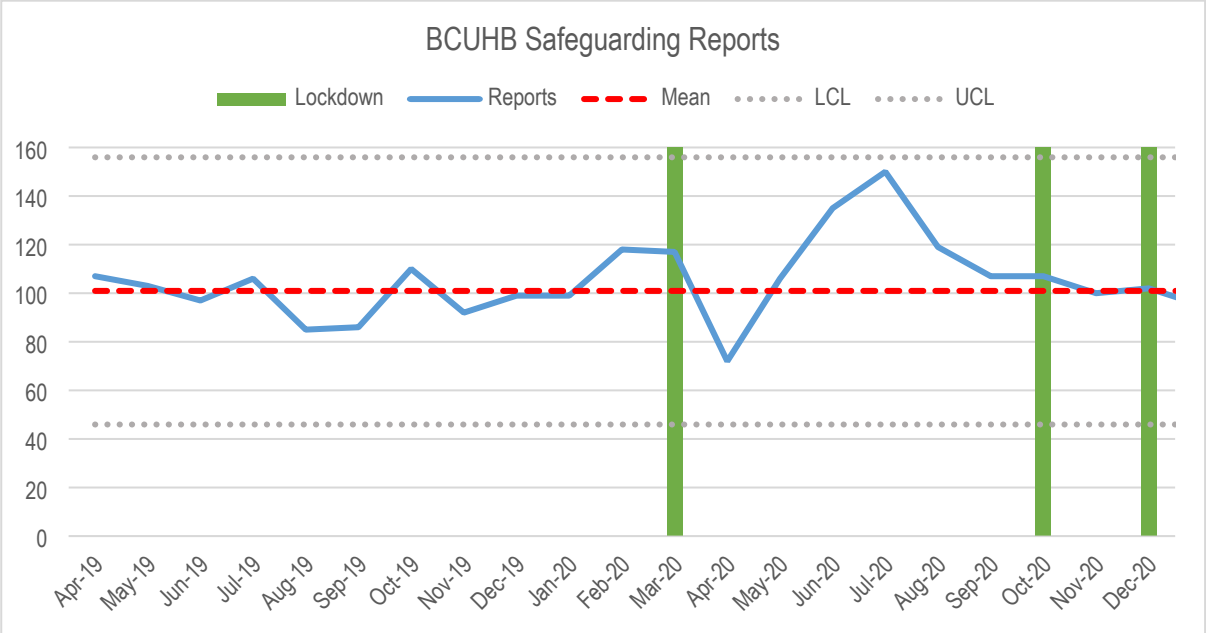
The Corporate Safeguarding Team Web Page contains useful information that can direct individuals to the process they need to follow and has the reports available for them to complete, the ease of this system could be also supporting the trend.

Table 2: Adult at risk reports by year.

Year	Reports
2016-17	986
2017-18	1034
2018-19	1113
2019-20	1219
2020-21	1284
2021-22	1407

2.2.5 It can be seen in Fig.1 below that during the government directed lockdown period and, in the month, following this, there is a decline in the number of Adult at Risk Reports. This is likely to be in relation to less professionals having in person contact with patients mostly in the community, care home or outpatient setting. BCUHB Corporate Safeguarding Team have worked closely with community colleagues to emphasise the need to have professional curiosity and consider safeguarding during those essential visits that are permitted during these times.

Fig 1: Adult at Risk reports April 2019 to March 2022.



2.2.6 Development of the role of the Designated Safeguarding Person (DSP) has continued in 2021-2022. This ensure ensures that staff who have concerns are supported at the earliest stage. This allows for immediate actions, required to make safe the individual/situation, to be undertaken and determine the appropriate safeguarding framework.

2.2.7 The Designated Safeguarding Person continue to work closely with staff, ensuring that on receipt of the adult at risk report they promptly request the details for assurance in relation to the safety of any individual(s). Supporting evidence of this can include updated care and treatment plans, risk assessments and where necessary more detailed interventions.

2.2.8 A workshop for Corporate Safeguarding Team around roles and responsibilities as outlined within the Wales Safeguarding Procedures 2019 was held in July 2021. The Standard Operating Procedures have been developed with the aim to reduce deviation from process and increase efficiency and parity of services offered across BCUHB. As the Corporate Safeguarding Team develops, this will be revisited in 2022-2023 reflecting the review of the adoption of the process thus far in 2021-2022.

2.2.9 The Wales Safeguarding Procedures (2019) has introduced a process that enquiries are led by the Local Authorities as Statutory Agencies. BCUHB have developed the role of Enquiries Lead to support this requirement. The first phase of the Enquiry Lead Roll out began in October 2021. Initially the evaluation and learning from the initial phase of roll out was planned for January 2022 with the further roll out across the Health board to follow this. However, it has not been possible to complete this review in the timescale envisaged as further COVID cases from the Omicron variant resulted in a surge of demand for services to focus on clinical priorities. This review will now take place in Q1 and Q2 2022.

2.2.10 In preparation, a survey has been sent to clinical areas in East and West Area that had been identified first implementation phase and where training had been provided. The clinical areas identified include both community and Inpatient services. The Local Authorities involved in the initial roll out (Wrexham Local Authority and Ynys Mon Local Authority) are aware of the clinical areas/teams who are participating.

Priority Action 1 (2022-2023).

Roll out of the Enquiries Lead role across all areas of BCUHB as outlined in Wales Safeguarding Procedures.	March 2023

2.2.11 All activity is reviewed and evaluated within the respective multi-agency Safeguarding Board Delivery Groups as well as internal (BCUHB) Safeguarding Forums. The benefit of multi-agency engagement allows for the triangulation of data and actions for implementation from the lessons learnt. An example of this is seen from the intervention and developments within Heddfan as outlined in 3.6 where multiple agencies worked collaboratively to achieve quality improvement and improved relationships, which ultimately provides enhanced care.

2.3 Category of Abuse

Table 3: Adult at Risk reports by Category of Abuse.

Category of Abuse	2020-21	2021-22	Trajectory
Neglect	488	503	↑
Physical	482	424	↓
Emotional	140	123	↓
Financial	72	83	↑
Sexual	55	47	↓
Multiple	0	126	↑
Not Recorded / N/A	42	100	↑
Self-Harm	5	1	↓
Total	1284	1407	

2.3.1 Table 3 records the Adult at Risk Reports from 2021-2022 by category of abuse. It also includes the trend compared to 2020-2021.

Allegations of neglect (this include Self-Neglect) is the most reported category of abuse for Adult at Risk Reporting from BCUHB. This is consistent with what had been recorded in 2020-2021. There has been increased Adult Safeguarding Supervision sessions in relation to self-neglect to respond to this continued increase. The Corporate Safeguarding Team have also become involved in the adverse discharge process where many reports in relation to neglect are generated where learning can be collated and shared. This forum had been stood down initially in 2021-2022 and was managed via the clinical governance team however at the latter part of Q4 (March 2022) these forums have resumed. These forums are multi agency and include local authority colleagues.

The learning outcomes are shared regionally through safety briefings and safety summits along with Putting Things Right (PTR) groups. The learning is

also aligned and added to Datix in the form of a Make it Safe process. Embedding this learning forum in all areas again will support an improvement in patient experience on discharge from hospital wards.

2.3.2 The themes and categories from the Adult at Risk Reports are \discussed within Safeguarding Supervision across the region may be maintaining the awareness of this category that may have been under reported prior to 2020.Prior to this physical abuse was the highest reported category. The increase in reports in relation to individuals in care homes could also be a contributing factor to the maintained number of reports.

2.3.3 When reported into areas, Table 4, shows neglect as the most prevalent in the Centre and East areas with, allegations of physical abuse most prevalent in the West. The possible rationale for this variation in the West area could correlate to an increased number of peer-on-peer altercations within the inpatient setting for individuals living with dementia. The difference between categories of neglect and physical abuse in central area is not statistically significant. There are similarities in relation to West and Central area regarding peer-on-peer altercations within the inpatient setting for individuals living with dementia.

There is a legal requirement to report alleged incidents of physical altercation between patients who are not able at the time to demonstrate capacity to decide on this action. Corporate Safeguarding team will continue to attend governance meetings to provide professional proportionate enquiry and encourage discussion.

Table 4: Adults at risk reports by category of abuse by area.

Category of Abuse	West	Central	East	Out of Area	Total
Neglect	119	143	231	10	**503**
Physical	137	140	125	22	**424**
Multiple	34	44	45	3	**126**
Emotional	40	36	43	4	**123**
Not Recorded / N/A	44	25	26	5	**100**
Financial	19	30	32	2	**83**
Sexual	9	17	15	6	**47**
Self-Harm	0	0	0	1	**1**
Total	**402**	**435**	**517**	**53**	**1407**

2.3.4 Corporate Safeguarding team have provided feedback in Safeguarding forums the increase in category of abuse not being recorded. In 2019-2020, there were 41 reports with the category of abuse not recorded, this is compared to the 42 recorded in 2020-2021. The figure for 2021-2022 has increased to 100.This can delay the deployment of appropriate guidance and support. In a wider context the emerging themes may not be able to be identified as quickly so as preventative intervention can be sought.

2.4 Location of Alleged Abuse

Table 5: Adults at risk reports by location type.

Location Type	2020-21	2021-22	Trajectory
Care Homes	419	499	↑
Own Home	399	469	↑
MH Units	266	176	↓
Wards	121	139	↑
Other/Not Recorded	79	124	↑
Total	**1284**	**1407**	

2.4.1 Table 5 shows that reports from Care Homes have seen a 19% increase, (419 reports in 2020-2021 to 499 reports during 2021-2022).

2.4.2 As a result of this increase, Care Homes are the most prevalent location of abuse. They account for 35% of reports submitted. The increase is likely down to the factor that within this period an increased number of professional bodies have now been able to attend care home facilities following the restrictions from the COVID-19 pandemic.

2.4.3 The Corporate Safeguarding team continue to work closely with CHC teams, Area Practice Development practitioners and District Nurses in addition to colleagues within the Local Authority and Care Inspectorate Wales to review cases, and support early intervention and prevention.

Safeguarding Supervision with District Nursing teams has increased across all regions to strengthen the application of the All Wales Safeguarding Procedures (2019).

2.5 Adults at Risk – Performance and Activity overarching for MHLD

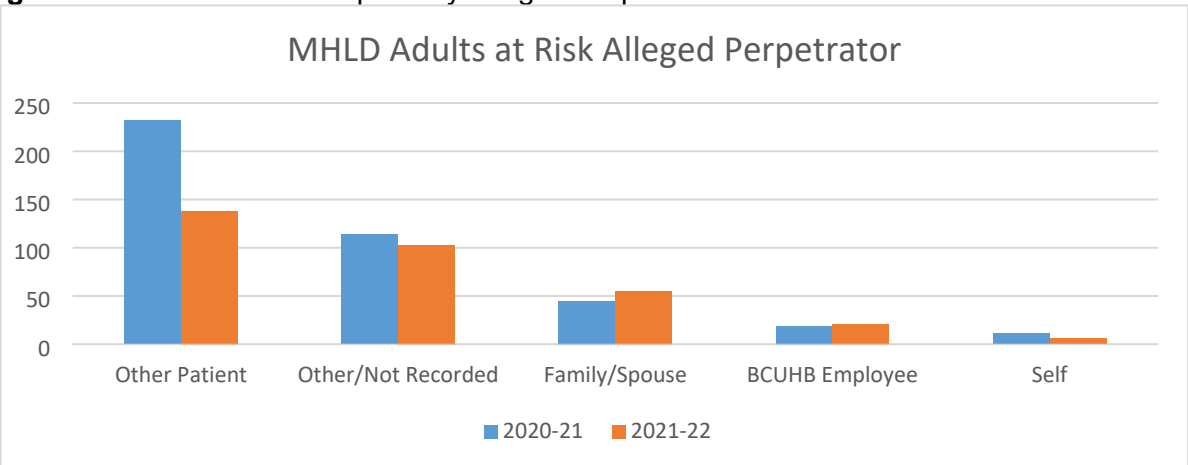
Table 6: MHLD Adult at Risk reports by area.

Year	West	Central	East	Forensics	Rehab	Learning Disability	Total
2020-2021	125	89	128	7	1	71	421
2021-2022	71	62	93	8	3	86	323
Year on Year % Increase/decrease	**↓43%**	**↓30%**	**↓27%**	**↑14%**	**↑200%**	**↑21%**	**↓23%**

2.5.1 Table 6 highlights that in 2021-2022 there have been 323 Adult at Risk Reports sent from the MHLD division which equates to 23% of all Adult at Risk Reports received. The number of submitted Reports has reduced by 23% in comparison to the 421 MHLD reports received during 2020-21. This change in reporting within the MHLD Division is a direct result of targeted engagement between MHLD staff and the organisational Designated Safeguarding Person (DSP) prior to submission. In addition, the most engagement with Safeguarding Supervision support sits within the MHLD Division. This supplies an added layer of safeguarding awareness and support.

2.5.2 Corporate safeguarding continues to attend MHLD specific governance meetings. These include the MHLD Regional Falls group, Putting Things Right (PTR), and the MHLD Safeguarding Forum. These arenas give opportunity to share learning and good practice within the MHLD division as well as supporting discussion around recent incidents and activity.

Fig 2: MHLD Adult at Risk reports by Alleged Perpetrator.



2.5.3 The alleged perpetrator is recorded as other patient in 42% (n=138) of MHLD reports.

37% (n=118) of the MHLD reports have been with regards to patient on patient alleged physical abuse. This percentage is down from the 47% of 2020-21 data.

This improvement is due to the Corporate Safeguarding Team having worked in partnership with older adult inpatient Mental Health Units in relation to prevention and early intervention as well as collaborative working in producing behavioural support plans that are meaningful to the person to aid in reduction of risk of physical abuse towards others. It is important to record that consent from an alleged adult victim is paramount when considering reporting under the Adult at Risk framework. If the patient lacks the capacity to consent an MDT, held with all individuals involved in the patients' care, will decide the best course of action.

2.5.4 There has been continued support of the community rehabilitation services including targeted supervision with teams across BCUHB. There has been an improvement in the sharing of information in relation to rehabilitation services where an adult at risk process is being followed outside the geographical area of North Wales. This was previously a concern as Corporate Safeguarding team were not always made aware and therefore not involved in supporting BCUHB individuals where adult at risk reports had been generated.

2.5.5 Promoting the role of Designated Safeguarding Person has helped support this positive approach promoting the voice of the person to ensure they are being heard and supporting the person to achieve what they set as outcomes. Adult at risk process potentially previously been viewed as a process done as an immediate and automatic response to an incident rather than explored further once immediate make safe measures are in situ.

Through the Designated Safeguarding Person process the focus has been more on proactive and preventative interventions through earlier liaison.

2.6 HASCAS Investigation and Donna Ockenden Review

2.6.1 HASCAS 8 / Ockenden 6 recommendations have been completed. The increase in safeguarding activity, complexity and the introduction of new regulations has resulted in the review of the Corporate Safeguarding Team structure. The Corporate Safeguarding Business Plan is in a process of being finalised for submission. This includes new positions within the service, specifically three dedicated safeguarding specialists to support the MHLD Division, and to reinforce BCUHB's safeguarding commitments and to execute the new Mental Capacity (Amendment) Act 2019 and the Liberty Protection Safeguards Code of Practice.

Priority Action 2 (2022-2023).

Successful recruitment of all vacant posts within Corporate Safeguarding and consideration of the wider structure.	December 2022

2.7 Safeguarding Governance and Reporting Framework

2.7.1 The Safeguarding Governance Reporting Framework is used to ensure organisational wide reporting, escalation, and engagement. It has proven to be robust both at strategic and operational services level.

2.7.2 Review of the Adult Safeguarding Database has been completed within the target for completeness in March 2022. This Database supports the provision of richer data for reporting. Weekly monitoring of the data is undertaken to alert in real time any areas of activity that may require further Safeguarding support.

2.7.3 Attendance at the North Wales Safeguarding Board and supporting subgroups has been reported to be 100 % compliant by BCUHB Corporate Safeguarding. This enhances the North Wales' multi-agency approach to safeguarding by allowing learning and information sharing across all partner agencies therefore ultimately promoting and preventing those Adults at Risk.

2.7.4 All Adult at Risk activity continues to be monitored through attendance of the local HARMS and Putting Things Right meetings, Safeguarding Forums in turn report back to the Local Delivery Groups for each area.

2.8 Once for Wales Concerns Management System (OfWCMS)

2.8.1 The Once for Wales Concerns Management System will change in the way we report Adults and Child at Risk and will also change the way we submit Deprivation of Liberty Safeguards (and eventually Liberty Protection Safeguards) applications.

2.8.2 In addition, a comprehensive training programme will be needed to ensure that all staff are fully aware of the system and how to report concerns.

2.8.3 Corporate Safeguarding have engaged in CQMS meetings. Provided comments that were shared with PHW in relation to the Adult/Child at Risk reporting framework as currently the system would not meet statutory or regional requirements under the Wales Safeguarding Procedures.

2.8.4 Escalation of the proposed new system have bas been made to the North Wales Safeguarding Board as they were unaware of the Once for Wales Concerns Management System. Welsh Government and Public Health Wales have met with key stakeholders across North Wales, to include all 6 Local Authorities, with the view to the Local Authorities adopting the Once for Wales Concerns Management System into practice.

2.8.5 The team have had further engagement with Welsh Government regarding the development of a module for Liberty Protection Safeguards. This has activity has not progressed due to the delay in the release of the Liberty Protection Safeguards Code of Practice.

2.8.6 We will have continued engagement within local and national meetings and support ongoing consultation in relation to the potential implementation and impact of the new system. Multi-agency engagement to ensure that partner agencies are fully aware of any changes is undertaken and a review of all training packages is pending to ensure compliance.

3. Safe Care

3.1 Rationale

3.1.1 All organisations must have a safe recruitment process that considers the safety to children and adults at risk. Corporate Safeguarding Team has strong links with the regional outreach advisor for Wales DBS (Disclosure and Barring Service) and have had them present in Safeguarding meetings to enhance awareness of the service.

3.1.2 Safeguarding concerns about employees should be raised and addressed utilising an effective system that should be in place. Departments and professionals delivering services must take full consideration of their safeguarding responsibilities.

3.1.3 To support BCUHB to achieve the standard highlighted in 3.1.2, Corporate Safeguarding positively liaise with and support Human Resources services to promote compliance with DBS requirements and Section 5 (Allegations against Persons in Position of Trust) legislation.

3.1.4 Corporate Safeguarding Team have supported with 80 Section 5 referrals in relation to persons in Positions of Trust who are employees of BCUHB. This is an increase from 49 recorded in 2020-2021. The profile of this process has been increased through discussion in governance forums and through colleague's experiences.

Priority Action 3 (2022-2023).

Action to work with WOD, Information Governance, NWP and Safeguarding in relation to agree template for reporting.	October 2022

3.2 Safeguarding People living with Dementia

3.2.1 An appointment has been made to the role of the Regional Adult/Dementia Safeguarding Specialist for Safeguarding to strengthen the Dementia strategy and safeguarding structure. The post-holder's role will focus on supporting the most complex cases, where specialist knowledge and significant expertise will be required to ensure best practice is in place for Adults and Adults with both Dementia and/or Mental Capacity concerns. Scoping in relation to individuals living with Dementia on acute wards in district general hospitals and community hospitals and services has commenced. Early indications have guided supervision for ward areas in correspondence to advocating safeguarding for those people who are not able to fully instruct this process themselves.

Priority Action 4 (2022-2023).

On recruitment of the Regional Safeguarding Adult/ Dementia Lead, commence mapping and scoping of patients within acute and community services.	March 2023

3.2.2 The Adult/Dementia Safeguarding Specialist is a member of the National Steering group for Dementia in Wales along with the North Wales Regional Collaborative Team.

The focus of Q3 and Q4 was to begin the implementation of All Wales Dementia Care Pathway of Standards into practice. There has been progression in relation to standards pertaining to memory assessment services and community partnership working. These standards are reviewed within the North Wales Regional Collaborative and aspects in relation to Safeguarding are emphasised. Examples of this are supporting with advanced directives and lasting power of attorney at initial stages of diagnosis of Dementia. There is also now a focus on immediate emotional support following diagnosis in those following hours and weeks where the individual may be at greater risk of self-harm.

Priority Action 5 (2022-2023).

The Regional Adult/Dementia Safeguarding Specialist to continue to support the full implementation of All Wales Dementia Care Pathway of Standards into practice within BCUHB services.	December 2022

3.2.3 The Adult/Dementia Specialist has supported with the development of the Dementia Friendly Hospital Charter. This will be launched on 06/04/2022 with pilots in rehabilitation wards in partner health boards. The Adult/Dementia Safeguarding Specialist will work collaboratively with acute hospital wards and Dementia Consultant Nurses in the Health Board to embed the principles of VIPS framework in preparation for roll out in our health board.

The VIPS framework was developed by the university of Worcester and its acronym carries the below concepts

V - Values People through valuing and promoting a person's rights.

I - Individual needs, provides individualised care according to needs.

P - Perspective of the person, understand care from the perspective of the person living with Dementia.

S - Supportive social Psychology, promoting positive social environments to promote and maintain relationships.

3.2.4 In collaboration with multiple disciplines the Adult/Dementia Specialist has developed a pocket prompt for health care and nursing staff to improve experience of those individuals on our acute hospital wards living with Dementia.

3.2.5 In collaboration with Consultant Nurse for Dementia the Adult/Dementia specialist has completed a Dementia Care Mapping exercise in line with item 16 of the All-Wales Dementia Care Pathway of Standards. This was within an acute MHLD inpatient setting for People living with Dementia in the East area. Full Covid-19 precautions were followed. The provision of Dementia Care Mapping (DCM) will continue a 3 monthly basis and be replicated across all acute MHLD inpatient setting for People living with Dementia and expanded to Care of the Elderly Wards and Community Hospitals over the course of 2022-2023

Dementia Care Mapping is a valuable tool to evaluate and learn about person-centred enabling practice. By embedding this tool will help us to improve care across services. This tool will support evidence that ensures services are meeting and responding appropriately to people's needs at all stages of the person's journey. One example of practical learning that was immediately implemented from recent exercise, is we were able to identify a significant falls hazard where a low table was being misidentified as a continuation of the flooring. The table was removed, and this encouraged more independent mobility of individuals, which allowed more interaction with other peers and improve wellbeing. The appreciative focus of the feedback from the exercise allows staff to see the positive impact they can have and encourages this to be done more frequently to allow a greater sense of well-being for the individual in their care. The appreciative approach to feedback can also impact on staff well-being and resilience which is then returned in the compassion of care provided.

A second observation from the recent Dementia Care Mapping exercise was the ability to continue to communicate none verbally through facial expressions even though staff were wearing Personal Protective Equipment. Smiles were still initiated and shared by patients even though they were unable to see the staff members face there was a response to the potential feeling. This was particularly pertinent when providing comfort for a person in distress.

It is acknowledged that Dementia Care Mapping is not an approved tool for acute general district hospital settings, however, the application of its principles would be beneficial, and discussions are ongoing about how this will be progressed. In England there has been the use of an observation tool called sit and see that is approved for usage in acute general district hospital settings. Sit and See was developed by Lynne Phair and is noted in the Francis report (Hard Truths) in response to the Mid Staffordshire NHS Foundation Trust Public Enquiry as an example of good practice. Similarly, to Dementia Care Mapping Sit and see looks at holding the person living with dementia at the centre of the interaction and exploring how that interaction may be accepted by the person living with Dementia. Unlike Dementia Care Mapping it is not aimed at an appreciative enquiry format of shared feedback and is more direct in raising the issue identified. The format and repeatability of the sit and see session is not as evidence based as Dementia Care Mapping at this time but also is in its infancy in comparison. There is currently no member of BCUHB staff trained to practice sit and see despite its simple principles its application can only be completed following completion of training.

Priority Action 6 (2022-2023).

The Regional Adult/Dementia Safeguarding Specialist to explore the application of an observation tool within the district general hospital wards to provide assurance of person-centred care and wellbeing of individuals living with dementia at that time on Acute general Hospital wards.	December 2022

3.2.6 The Regional Adult/Dementia Safeguarding Specialist had been supporting the Central area Corporate Safeguarding Team as interim Area Safeguarding Manager whilst this position was being recruited into. This interim role has allowed for engagement with fundamental stake holders in the area which will support moving forward in their Adult/Dementia Safeguarding Specialist role. It is acknowledged that the scoping exercise with primary care and in particular GP surgeries has not been able to be initiated at this time due to resource capacity within the team.

Priority Action 7 (2022-2023).

Scoping for service safeguarding needs along with under and over reporting of incidences for those individuals living with dementia receiving care on our general wards, community hospital and primary care.	December 2022

3.2.7 Within Quarter 3 and 4 the Regional Adult/Dementia Safeguarding Specialist liaised with Hospital areas in relation to the safe re introduction of the John's campaign. These discussions were positive and liaison with Infection Prevention Control (IPC) Team to ensure that IPC guidance was met.

3.2.8 Once the role of the Regional Adult/Dementia Safeguarding Specialist is established it will enhance staff access to specialist support and guidance thus improving confidence to provide safe and effective care to adults, particularly those living with dementia. Through development of staff and services in line with the All-Wales Dementia Care Pathway of Standards and the implementation of the Dementia Friendly Hospital Charter there is expected improvement in the experience for patients.

Priority Action 8 (2022-2023).

To benchmark against relevant All Wales Dementia care pathway of standards in relation to ward/ service accreditation.	March 2023

Priority Action 9 (2022-2023).

To support the implementation of the Dementia friendly Hospital Charter.	March 2023

3.3 The Sexual Safety - Task Group

3.3.1 The MHLD Division have co-produced with Caniad service user led guidelines. The guidelines provide staff and patients for when an individual is admitted onto a Mental Health ward in relation to sexual safety. Consultation sessions took place across North Wales between BCUHB staff, partner agencies, third sector agencies and service users.

3.3.2 The final draft document has been ratified by The Policy and Procedure Group in MHLD. The Guidelines were presented to the Patient Safety and Quality Group in November 2021 and changes to the document were requested. The Interim Director of Nursing for MHLD is addressing these changes at the time of report.

3.3.3 The training sessions that were being delivered have not progressed. There have been changes within Caniad and the person from CAIS who had agreed to develop and deliver the training package is no longer able to do so and a replacement has not been identified.

Priority Action 10 (2022-2023).

To support the Sexual Safety Group with training and evaluation of the co-produced MHLD guidance for patients and staff.	September 2022

3.4 Commissioned Care

3.4.1 During 2021-2022 Corporate Safeguarding have continued to support colleagues by working in partnership with the independent sector, other commissioners, HIW, Police and Local Authorities to ensure residents are safeguarded. There have been several challenges during the COVID-19 Pandemic, including the safety of staff whilst undertaking key duties.

3.4.2 The Corporate Safeguarding Team continue to be fully engaged in the Care Home Quality and Safety Group meetings, the Quality Assurance Framework and support the Continuing Health Care Teams along with District Nursing Teams. This will allow for a focus on communication and engagement with care homes to improve outcomes with individuals receiving their service and provide specific support from a multiagency approach. This is reflected in the number of Adult at Risk Reports received from care homes.

3.4.3. Corporate Safeguarding team are also represented on the following task and finish subgroups:

- Clinical/Quality/Contract Monitoring.
- Data Collection and Triangulation.
- Individual and Staff Feedback.
- Education, Training, and support.

- Escalating Concerns.

This will assist in embedding the Wales Safeguarding Procedures 2019 into these processes and as such support the delivery of safe effective care in commissioned services. When subgroups have completed what is set out in the terms of reference this will form the basis of the framework.

Priority Action 11 (2022-2023).

To support the development and implementation of the Quality Assurance Framework for commissioned services, embedding Wales Safeguarding procedures into the programme.	November 2022

3.5 COVID-19 Response

3.5.1 The Corporate Safeguarding response to the COVID-19 Pandemic has been substantial. A Safeguarding COVID-19 Action Plan was developed to identify and action activity required to mitigate potential risks across the safeguarding agenda.

3.5.2 The Corporate Safeguarding COVID-19 plan has been successful in:

- BCUHB Corporate Safeguarding maintaining a presence in the clinical area where required to support patient cohort as well as 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.

Where the training statistics are low, managers are requested to develop action plans to address this. These are monitored through the Area Safeguarding Forums and Quality and Safety Groups.

3.5.3 BCUHB safeguarding have provided face to face safeguarding training to the mass vaccination centers in relation to capacity for people attending for their vaccinations including children.

3.5.4 Corporate Safeguarding have continued working with respective commissioning and CHC teams to review any concerns raised about all current BCUHB commissioned placements. This has resulted in risk assessed placement visits to support the escalating concerns agenda.

3.5.5 Working closely with clinical areas has continued where an improvement in quality of reports and associated risk documentation is required. This has included the delivery of bespoke training.

3.5.6 As the COVID-19 Pandemic continues, it is expected that we will continue to provide services in a format similar to that set out above, ensuring where required and safe to do so that there is a physical presence.

3.6 Mental Health & Learning Disabilities [MHLD] Inpatient Services

3.6.1 Following concerns raised in relation to specific cases relating to safeguarding at the MHLD units' various levels of activity to support immediate action, long term interventions and support, and current/historical safeguarding benchmarks was undertaken.

3.6.2 As a result, there is effective communication between MHLD services and Corporate Safeguarding as in the majority of cases contact is made prior to submission to discuss any potential Safeguarding Concerns. This promotes early actions and intervention to prevent ongoing or future incidents.

3.6.3 The quality of the Adult at Risk Reports being submitted was also highlighted as a concern. All staff Band 6 and above have received or are undertaking training on quality assuring the reports prior to submission. The quality of the reports has improved which has been reflected in feedback from the Local Authorities. This will continue to be reviewed as part of the Audit process with the division.

3.6.4 In 2021-2022 BCUHB published several reports into concerns about Mental Health inpatient units. Amongst the themes found from these reviews was the application of the Wales Safeguarding Procedures (2019) within daily practice.

3.6.5 In partnership between the corporate safeguarding team and MHLD services a Safeguarding Improvement Action Plan. One of the focus areas of the Action Plan was to support the MHLD Division to review staff understanding and application of Wales Safeguarding Procedures.

Through increased safeguarding supervision and engagement with staff we are able to show assurance that the risks and support needs of the person viewed as an Adult at Risk are fully considered by clinical staff involved, including when to submit an Adult at Risk Report, when to engage with the Corporate Safeguarding team, when to consider the risk of harm, abuse, or neglect (including self-neglect), and when to over-ride consent if somebody has fluctuating mental capacity.

3.6.6 In addition, the use of ‘professional curiosity’. Professional Curiosity is the skill to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and challenge. It is about understanding our own responsibility and knowing when to act, rather than making assumptions or taking things at face value). It includes a greater appreciation of the correlation and increased risk factors and indicators relating to Mental Health, Cuckooing and County Lines drug gangs.

3.6.7 Following a serious untoward incident where a patient did not receive intervention as expected, the Corporate Safeguarding team provided an immediate and sustained response to support the improvement in practices within the area.

3.6.8 The application of the Divisional Observation Policy was highlighted as an immediate concern. The roles and responsibilities of all staff in relation to this were emphasised through management supervision and provided in writing to all staff across the Division for their awareness.

3.7 Emergency Departments (ED)

3.7.1 Concerns have been raised by our regulators Health Inspectorate Wales relating incidents within BCUHB Emergency Departments. Corporate Safeguarding have also noted the inferior quality of Child at Risk Reports, Safe Lives Risk Assessments and Adult at Risk Reports within Emergency Department provisions across BCUHB. It has also been identified times where Safeguarding has not been considered in the interventions taken by practitioners within the Emergency Department services. It must be acknowledged that the unprecedented pressure and demand on these departments to include staff absences due to sickness (to include COVID-19) and vacancies. In line with widespread practice within Corporate Safeguarding we have taken a supportive arm approach to assist in learning and improvement within the Emergency Departments.

3.7.2 Additional concerns highlighted included:

- Poor handwriting, record keeping and poor-quality scanning.
- Documents being incomplete, lacking context and delay in submission of reports.
- Patient presenting with multiple pressure ulcers these are not always appropriately recorded nor safeguarding consideration evidenced.
- Falls and their mitigation were not always supported by multifactorial falls risk assessment.

The combination of these themes results in individuals not always getting the treatment they require in a timely matter which may cause harm and distress. Where safeguarding processes are not followed this pose significant risk.

3.8. Positive approach and interventions

3.8.1 Safeguarding Area Managers have been in liaison with Heads of Nursing for Emergency Departments in relation to the development of the Safeguarding Improvement Action Plans for their respective area. This continues to be in progress alongside those plans following recent HIW reviews in both Ysbyty Gwynedd and Ysbyty Glan Clwyd Emergency Departments. The Head of Safeguarding Adults has instigated a Benchmarking Exercise across all 3 Emergency Departments. This has allowed for the sharing of information and learning and the implementation of good practice identified across the areas. This is undertaken in partnership with the Heads of Department and the close working relationships with the Area Safeguarding Managers. This has helped to develop relationships not just with Emergency Department and Corporate Safeguarding but also regionally between the Emergency Departments themselves.

3.8.2 It has been already identified that work is to be undertaken to streamline the Safeguarding Reporting on the Symphony System. The use of an appreciative approach and having a can-do attitude has supported the implementation of some initiatives across the regions. Some of the initial initiatives have been around raising awareness of reporting pressure ulcers on admission and also the facility to support patients who are waiting in ambulances to receive intentional rounding and assuring comfort needs are met during this stay.

3.8.3 Training compliance is highlighted as a considerable concern, particularly Violence Against Women, Domestic Abuse and Sexual Violence. The medical staff is a more significant challenge it is reported this is due to the high turnover of Doctors within Emergency Departments.

3.8.4 Safeguarding Area Managers have been in liaison with Heads of Nursing for Emergency Departments to address any barriers to this training. Safeguarding Practice Development Leads have removed any caps on attendance limits for the virtual training to facilitate attendance. Additional sessions have been facilitated for Emergency Departments staff to attend unfortunately attendance was poor. This is a priority action recorded in the Safeguarding improvement plan for all Emergency Department services in BCUHB.

Table 7: **Emergency Departments Training Compliance March 2022.**

ED March-22 Compliance	Staff	MCA – Level 1	MCA – Level 2	Adults – Level 1	Adults – Level 2	Children's – Level 1	Children's – Level 2	VAWDASV	Trend
YG Medical	52	55.8%	48.0%	59.6%	50.0%	78.8%	48.7%	46.2%	↓
YG Nursing	69	89.9%	88.4%	88.4%	85.5%	88.4%	67.7%	73.9%	↓
YGC Medical	39	56.4%	56.4%	61.5%	51.3%	59.0%	50.0%	38.5%	↑
YGC Nursing	96	74.0%	70.8%	74.0%	75.0%	69.8%	81.6%	63.5%	↑
WMH Medical	36	50.0%	50.0%	66.7%	55.6%	58.3%	78.0%	47.2%	↑
WMH Nursing	108	84.3%	78.2%	86.1%	83.9%	86.1%	87.0%	71.3%	↑

Priority Action 12 (2022-2023).

Continue to explore ways of improving Mandatory training compliance within the Emergency Departments (ED's) of BCUHB to be assured that the staff have the knowledge and skills to address presenting safeguarding concerns appropriately.	December 2022

Priority Action 13 (2022-2023).

Task and Finish Group to develop a streamlined appropriate Safeguarding reporting direct from Symphony.	December 2022

3.9 Audit Quality of Adult Safeguarding Documentation.

3.9.1 During 2021-2022 Desktop Reviews that were undertaken identified learning with common themes. These themes included inferior quality information within the reports and standards of associated Safeguarding Documentation such as Safeguarding Risk Assessments and Protection Plans that provide assurance that immediate safeguards are in place.

3.9.2 The audit commenced in April 2021 and consisted of ten (10) reports per quarter selected randomly. This process is completed by adult safeguarding specialists across each Area. The audit consists of 14 quality indicators with the option to include narrative qualitative information also. The synthesised data then supports in identifying themes and how any learning will be shared.

Reports are rated as Excellent, Good, Average or Poor.

Excellent - To achieve an excellent score at least 13 quality indicators need to have been achieved or rationale as to why not required.
Good - To achieve a good score at least 10 quality indicators need to have been achieved or rationale as to why not required.
Average - To achieve an average score at least 8 domains need to have been achieved or rationale as to why not required.
Poor - If less than 8 domains have been achieved the score should be recorded as poor.

3.9.3 The findings from the audit showed that overall, the reports have been of a good standard that has enabled the Adult at Risk Processes to continue. There were some reports that were found to have poor levels of detail recorded on them.

Table 8: **Audit analysis.**

Area	Excellent	Good	Average	Poor
East	18	16	3	3
Central	16	17	3	4
West	18	14	4	4

3.9.4 Where the reports are of an inferior quality this is addressed to the relevant clinician or clinical area. This also occurs when they are submitted, and the Designated Safeguarding Person undertakes their enquiries.

3.9.5 Actions:

1. Outcome of audits to continue to be shared within the relevant Safeguarding Forums and with the clinical areas that have been audited.
2. Areas where low standards are documented are identified to have their Safeguarding Training stats reviewed and an action plan requested to address the training levels.
3. Themes have been identified in the recording of the person's capacity or the need for advocacy.
4. A further theme that has emerged in Q3 and Q4 is there is limited information on the Adult at Risk report to identify what immediate actions to safeguard have been completed. This has been raised in supervision and will form the basis of reports and feedback within future Safeguarding Forums.

3.9.6 A further audit of quality for Adult at Risk reports was completed in parallel with the above but specifically for acute wards in Central Area.

Table 9: **YGC Audit Analysis.**

Reporting Quarter	Excellent	Good	Average	Poor
1	0	1	0	2
2	1	3	3	1
3	1	6	2	1
4	2	7	3	1

3.9.7 Themes for learning and development were as per broader scope audit:

- Not considering advocacy.
- Not recording person's views.
- Not including protection plan for the individual.
- Not including what has already been completed to immediately reduce risks.

Where the reports are of an inferior quality this is addressed with the relevant clinician or clinical area. This also occurs when they are submitted, and the Safeguarding Specialists undertake their enquiries.

3.9.8 Themes of Good Practice were also considered for the purpose of the specific audit for Central Area Acute wards and were as follows:

- Most Reports were timely.
- Informative as to what the concern being raised is.
- Always provided contact details of the person who can support with enquiries.

There is a trend of increasing reports being completed and submitted by Acute Wards at Ysbyty Glan Clwyd and is encouraging that there is also a trend for improved quality of the reports. 33% of reports were deemed good or above in Quarter 1 whereas almost 70% of reports are at this level in Quarter 4.

4. Adverse Childhood Experience (ACE) Informed

4.1 Rationale

4.1.1 Adverse Childhood Experiences (ACEs) such as sexual abuse, psychological/emotional abuse, physical abuse, domestic abuse, substance misuse, and mental illness have been shown to have a direct and immediate impact on a child's health and welfare, with long-term effects.

The safety of the child and the safety of the vulnerable adult who is responsible for caring for the child are inextricably intertwined. Reducing early exposure can reduce the influence on children and future generations.

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

4.2 Womens Pathfinder Process

4.2.1 Corporate Safeguarding has been attending the Womens Pathfinder (WPF) meetings on a monthly basis since its inception, as a 6 monthly pilot, during May 2021.

4.2.2 This is a conference that is led by the National Probation service however is a multi-agency therapeutic approach to caring for women offenders within the east area.

4.2.3 The case conference addresses the gender specific needs of women who are involved in the criminal justice system or those who may become involved. The aim is to promote positive well-being for women to support a reduction in offending/re-offending through a multi-agency, early intervention focusses and entire system approach towards support.

4.2.4 As an outcome, a package of care for women who are in or returning to the community with probationary orders is devised. It involves multi agency case discussions based around the content of the case conference report and includes the nature of the offending, reason for referral into the WPF, risk of serious harm information, needs and vulnerabilities, Information sharing from partners and appropriate actions set and allocated to relevant agency.

4.2.5 The benefits of the meeting include professionals having a better insight into the women's needs, avoids duplication of work and provides a more streamlined support approach.

4.2.6 It ensures that up-to-date information on local service provision. It also, importantly, reduces the need for women to repeat their history and personally disclose issues to multiple agencies and aids the women in being more confident in accessing services.

4.2.7 Other health representatives include, mental health, the harm reduction team in the Substance Misuse Service and also Flying Start.

4.2.8 From the Pilot's start on the 24th of May 2021 to the end of Q4, there have been a total of 26 cases discussed and BCUHB will continue to be engaged in this forum.

4.2.9 BCUHB Corporate Safeguarding will be participating in the review of the pilot.

4.3 Routine Enquiry Domestic Abuse in Emergency Department

4.3.1 Table 10 provides a sample of the number of adult attendances within the Emergency Departments at Ysbyty Gwynedd and Ysbyty Maelor whereby the HITS questions have been asked to adult patients. This sample data provides a baseline that is captured from the Symphony Patient Electronic System.

This will inform a registered audit on a quarterly basis for 2022-2023. Initial discussions have already taken place with the Heads of Nursing and Head of Safeguarding Adults.

Table 10: **Sample of Adult Attendances and HITS questions recorded.**

	Adult attendances	Number Adults HITS questions recorded	Number of adults not able to be asked
YG	3165	2942	89
YM	3499	117	575

4.3.2 Ysbyty Glan Clwyd Symphony System has only become live on the 1st of April 2022 and therefore same data was not available but will be for 2022-2023.

Priority Action 14 (2022-2023).

Support in the audit of compliance with Routine Enquiry Domestic Abuse within all Emergency Departments and Minor Injuries Unit.	March 2023

5. Learning Culture

5.1 Rationale

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

5.2 Adult Safeguarding Training

5.2.1 The following compliance data reports up to March 31st, 2022

Permanent and Fixed Term Temporary Staff

L1 Adults 84.82% L2 Adults 83.01%

Level 1 for adults has remained the same at the same percentage throughout 2022. Where the Level 2 for adults has improved. However, these remain below the 85% threshold required.

Both Level 1 and Level 2 training packages are completed via E-Learning. Level 3 Adult Safeguarding Training has been delivered via Teams. Face-to-face training delivery remains being delivered and this may be an impact on overall percentages as this had previously been the delivery method of choice for many staff.

Bank, Locum and Honorary

L1 Adults 67.28% L2 Adults 64.14%

Training compliance is monitored through the Safeguarding Forums in each of the three areas of the Health Board. Areas where compliance is lower than the 85% threshold are instructed to provide action plans as to how the training compliance is to be improved.

5.2.2 Safeguarding Level 3 training competencies are still not linked to individual staff on ESR. Corporate Safeguarding continue to raise this with WOD in both Mandatory Training Group and the Safeguarding Training Task Group requesting assurance and timeframes in relation to attaching Level 3 safeguarding training competencies to individual staff on ESR. The risk results in false assurance in the accuracy of compliance data reported to the Board. This is registered on the risk register Risks Risk ID 3756 (safeguarding) linked to Risk ID 4196 (WOD).

Table 11: **Level 3 safeguarding training sessions and attendances 2021-2022.**

West	Adult at Risk - Module A	Teams	1	18
West	Adult at Risk - Module B	Teams	1	19
East	Adult at Risk - Module A	Teams	1	4
East	Adult at Risk - Module B	Teams	1	5
Centre	Adult at Risk - Module A	Teams	1	15
Centre	Adult at Risk - Module B	Teams	1	16
				Total: 77

5.2.3 Table 12 highlights safeguarding compliance by area as a comparison from March 2021 to March 2022.

Table 12: **March 2022 Safeguarding Training Compliance by Area and Subject.**

Area March-22 Compliance	West	Central	East
MCA – Level 1	79.4%	77.0%	78.4%
MCA – Level 2	78.5%	79.6%	80.9%
Adults – Level 1	81.0%	78.5%	82.3%
Adults – Level 2	77.6%	78.1%	79.7%
VAWDASV	67.5%	65.6%	67.8%
Average Area Compliance	77.1%	75.8%	78.3%
Compliance Trend	↓	↔	↑

5.2.4 Continuing the trend of 2021-2022, the East area has the highest overall compliance of the three areas. Although the West is showing a decrease when compared to Q3, the reduction in compliance is minimal.

Table 13: **BCUHB Safeguarding Training Compliance by Module.**

Safeguarding Module	March 2021	March 2022	Trajectory
MCA – Level 1	74%	76.5%	↑
MCA – Level 2	75.4%	77%	↑
Safeguarding Adults – Level 1	76.9%	78.8%	↑
Safeguarding Adults – Level 2	75.2%	75.8%	↑
VAWDASV	75%	65.5%	↓

5.2.5 Table 13 identifies four out of the five safeguarding modules have seen an improvement when compared to 2020-2021.

5.2.6 Ysbyty Gwynedd medical and nursing staff have seen a decrease in overall compliance when compared to Q3. However, the reduction in compliance for nursing staff is minimal and they remain above the BCUHB target of 85% in five out of seven modules.

5.2.7 Ysbyty Glan Clwyd medical and nursing staff have seen an improvement with nursing staff seeing their overall compliance rise of 10 percentage points.

5.2.8 Ysbyty Maelor medical and nursing staff have also seen an improvement during Q4 with nursing staff reaching the BCUHB target in three of the Safeguarding modules.

Table 14: **March 2022 Safeguarding Training Compliance BCU Managed GP Practices.**

Mar-22 Compliance GP	Area	MCA – Level 1	MC – Level 2	Adults – Level 1	Adults – Level 2	VAWDASV
Canolfa Goffa Ffestiniog	West	73.7%	71.4%	68.4%	62.5%	63.2%
Longford House Surgery	West	77.8%	100.0%	77.8%	100.0%	66.7%
Criccieth Surgery	West	52.6%	50.0%	68.4%	70.0%	36.8%
Cambria Surgery	West	76.9%	83.3%	69.2%	75.0%	65.4%
Porthmadog Health Surgery	West	64.3%	83.3%	92.9%	83.3%	28.6%
Rhoslan Surgery	Central	10.5%	10.0%	15.8%	20.0%	10.5%
Healthy Prestatyn Iach	Central	89.0%	79.5%	76.8%	66.7%	78.0%
Rysseldene	Central	62.9%	70.0%	71.4%	60.0%	51.4%
Llys Meddyg	Central	0.0%	0.0%	0.0%	0.0%	0.0%
Meddygfa Gyffin	Central	100.0%	0.0%	100.0%	0.0%	100.0%
Beechley Medical Centre	East	40.0%	100.0%	40.0%	100.0%	50.0%
Pen y Maes Health Centre	East	75.0%	100.0%	83.3%	100.0%	83.3%
The Laurels Surgery	East	38.5%	100.0%	46.2%	100.0%	53.8%
Hillcrest	East	55.0%	66.7%	52.5%	53.3%	42.5%
St Mark's Dee View Surgery	East	88.2%	88.9%	94.1%	88.9%	88.2%
Panton Surgery	East	64.3%	83.3%	42.9%	50.0%	57.1%

5.2.9 Table 14 highlights that Safeguarding Training compliance continues to be an area of concern for most of the GP BCUHB Managed Practices. However, there is improvement whereby some modules are achieving above the BCUHB target of 85%. It is duly noted that % can be skewed when there is low staffing at the practices.

Priority Action 15 (2022- 2023).

Corporate Safeguarding team to support Primary Care Directors to update their action plans outlining how they will address poor compliance within the identified Practices within this report.	March 2023

5.3 Safeguarding Training Successes for the year 2021–2022

5.3.1 Bespoke Student Nurse Placement.
Corporate Safeguarding have worked collaboratively with Bangor University and BCUHB Nurse Education to offer 2nd year student nurses the opportunity to undertake a 5 day spoke placement with the Safeguarding Team. In preparation for the placement, all staff have been trained and an educational audit completed.

5.3.2 BCUHB Matron's Leadership Programme.
Corporate Safeguarding facilitated and developed a safeguarding workshop for the Matron's Leadership Programme and have been invited back to contribute to the 2022 programme.

5.3.3 North Wales GP Training Programme
Corporate Safeguarding facilitated and delivered Level 3 Safeguarding Training, & Child at Risk to 177 trainee GP's and GP Teachers. The evaluation was excellent, and a letter of thanks was received. We have been invited back to contribute to contribute to the 2022 programme.

5.4 Adult Practice Reviews (APR)

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

5.4.2 Table 15 provides a numerical picture of the Adult Practice Reviews undertaken since 2018.

Table 15 **– Number of APR from 2018-2022.**

Year	Number live APRs	Number signed off	Number Ongoing
2018-2019	3	1	2
2019-2020	2	1	1
2020-2021	0	1	0
2021-2022	1	1	1

5.4.3 In 2018-2019, there were 3 ongoing Adult Practice Reviews, one (1) was signed off and two (2) carried forward to 2019-2020. There were no additional Adult Practice Reviews in 2019-2020 however of the two (2) carried forward one (1) was signed off. In 2020-2021 there were no additional Adult Practice Reviews however of the one (1) carried forward. There is currently one (1) Live Adult Practice Reviews.

5.4.4 Within 2021-2022 there is a new Live Adult Practice Reviews that has had an initial panel meeting. The Head of Safeguarding Adults is the Chair for this Adult Practice Reviews in addition to other staff from the Corporate Safeguarding team as a panel member to support to the BCUHB staff from appropriate services. They have coordinated early learning from initial analysis and there is a theme in relation to a lack of application of the Self Neglect protocol.

5.4.5 The monitoring of the learning is undertaken by the North Wales Safeguarding Adults Board and internally by the BCUHB Safeguarding Forums. All Adult Practice Reviews and Domestic Homicide Reviews are standing agenda items for monitoring at Area and Divisional Safeguarding Forums reporting to the Safeguarding Governance Performance Group.

5.4.6 Key themes identified from practice reviews from 2018 to 2022 include:

- Lack of Care Coordination.
- Poor communication both internally and across agencies.
- Agencies working independently rather than collaboratively.
- Poor training compliance at individual, service, and organisational level.
- The person causing the harm may not be identified as an Adult at Risk themselves.
- The quality of record keeping and documentation.
- Lack of awareness of North Wales Safeguarding Board Self Neglect Policy noting this requires further revision.
- Routine Enquiry Domestic Abuse consideration and implementation within Emergency Department.

5.4.7 The obligation for BCUHB to lead on specified actions delegated from the recommendations in collaboration with partner agencies will have an impact.

5.4.8 The learning from the Adult Practice reviews is disseminated in a multitude of ways predominantly including Safeguarding Forums across the region using various formats to aid learning such as 7-minute briefing, supervision, amended training packages, the Safeguarding webpage, the quality, and Safety meetings and in desk top reviews.

Priority Action 16 (2022-2023).

Corporate Safeguarding to continue to support and mentor BCUHB staff who are Reviewers and Panel Members to include sharing key themes from the reviews and producing 7-minute briefings to share for learning across BCUHB Safeguarding Forums and Governance meetings alike.	March 2023

5.5 Desktop Reviews

5.5.1 The Safeguarding Escalation standard operating procedure provides a clear process of what is required when Safeguarding meets the Level 3 criteria of the SOP. A desktop review may be required to establish areas of concern to support and implement further learning through the triangulation of data

5.5.2 In 2021-2022 there has been Four (4) completed Desktop Review under this framework. Desktop reviews reflect a setting's practice and provide recommendations that would improve safeguarding measures. Findings from the desktop review completed in this reporting time frame that correlate to those findings of six (6) previous desktop reviews completed by corporate safeguarding team since July 2018 are noted below:

Room for improvement and action:

- Staffing levels and skill mix.
- Lack of escalation.
- Communication both internally and externally to the area.
- The voice of the patient is often absent.
- Standards of documentation to include Safeguarding.
- Omissions of fundamental information in adult at risk reports.
- Not considering Safeguarding procedures for Pressure Ulcers, Falls, Medication Incidents and Adverse Discharges.
- Not involving Corporate Safeguarding Team in Make, it Safe reviews.
- Not highlighting Safeguarding has been considered when completing Datix.

Good Practice:

- Investment in development of staff.
- Principles of confidentiality followed.
- A desire for patient desired change.

Priority Action 17 (2022-2023).

Concise thematic review into completed desktop reviews and outcome to be shared widely in Safeguarding forums and supervision.	COMPLETED

5.5.3 Staff in the reviews have engaged in the improvement plan and fully embraced the process. The plan will be monitored within the area Safeguarding Forums ensuring learning is implemented across the area. This also formulates the chairs assurance report that is presented within the Safeguarding Governance and Performance Group. Corporate Safeguarding positively provide support in quality improvement projects and compliment this with Safeguarding Supervision sharing themes and trends from gathered data.

5.5.4 For the Llandudno Hospital review, additional quality improvement plan has been developed with support and engagement from an Independent Safeguarding Board member, Community Health Council as well as representation from the Tawelfan Families group. There is organisational wide learning for implementation to include those of Safeguarding improvements. All the Safeguarding Actions for Llandudno Hospital has been completed and implementation commenced in Holywell, Ruthin, and Denbigh Infirmary to date of report.

Priority Action 18 (2022-2023).

Undertake Desktop Reviews as required in line with the Safeguarding Escalation SOP. Learning from internal reviews to be shared at Safeguarding Forums both Area and MHLD.	COMPLETED

5.6 Outcome and Learning

5.6.1 All Adult Practice Reviews and Domestic Homicide Reviews are a standing agenda item for monitoring at Area and Divisional Safeguarding Forums reporting to the Safeguarding Governance Performance Group.

5.6.2 To gain additional assurance Corporate Safeguarding have developed an action plan to benchmark recommendations from high profile Regional and National Safeguarding Reviews and investigations. The implementation of this work will continue to be a key priority for 2022-2023 as learning emerges from Reviews. This will offer further assurance that lessons learnt have been implemented by the Health Board.

5.7 Safeguarding Supervision

5.7.1 Adult Group and Individual Supervision continues to be provided although this has not been able to be on the scale that was projected for 2021-2022. However, this still provides a further portal to promote the adult safeguarding agenda and support staff to engage in the Adult at Risk process.

5.7.2 Adult Safeguarding Specialists have been using three (3) formats of safeguarding supervision:

- Individual (one to one).
- Group supervision.
- Telephone guidance in line with Designated Safeguarding Practitioner role.

5.7.3 The Group Supervision allows staff to discuss cases, reflect and learn in a safe and supportive environment. These sessions are offered to all BCUHB services.

5.7.4 The engagement in Safeguarding Supervision in Quarter 1 and 2 of 2021-2022 was established within the MHLD Division. The offers had been extended to Community colleagues in Quarter 2 and 3 as they had engaged and expressed a significant interest in receiving Safeguarding Supervision. Unfortunately, due to the challenges experienced in resources in this timeframe face to face sessions were limited or not possible.

Nevertheless, telephone or Microsoft Teams contact for any supervision was always available and utilised.

Table 16: **Number of Supervisions held by category.**

East				
Mode of Supervision	Numbers			
	Q1	Q2	Q3	Q4
Individual Supervision	5	1	1	1
Telephone Guidance	242	327	394	407
Group Supervision sessions	6	3	3	6
Central				
Mode of Supervision	Numbers			
	Q1	Q2	Q3	Q4
Individual Supervision	4	3	8	9
Telephone Guidance	249	324	360	376
Group Supervision sessions	6	4	7	6
West				
Mode of Supervision	Numbers			
	Q1	Q2	Q3	Q4
Individual Supervision	3	3	4	3
Telephone Guidance	260	303	356	367
Group Supervision sessions	2	1	3	2

5.7.5 Table 16 highlights how the COVID-19 Pandemic has had an impact on the delivery of individual supervision. This has been further influenced by staffing vacancy in East and West area and long-term sickness in Central area.

5.7.6 Priority activity for Quarter 1 and Quarter 2 of 2022-2023 will be to relaunch our active offer of individual safeguarding supervision, along with group supervision. There has been development of a further database to help facilitate this and record it using the record of discussion format.

With this increase, the Corporate Safeguarding team has invested in staff supporting through supervision and with bolstering awareness and resilience. Responsive supervision has increased to attempt to meet the demands of services. The trend and collaborative expectations have been shared in each of the Safeguarding Forums.

5.7.7 The themes discussed on request of the staff included.

- Wales Safeguarding Procedures.
- Self-Neglect Procedure.
- Complex Cases.
- Personal Wellbeing.
- Keeping Safe.

5.7.8 Feedback from attendees continues to highlight the positive impact on practice from the supervision sessions.

Examples of initial feedback include:

*"*It was really helpful for the team to support us with safeguarding"

*"*It is great to have expert guidance & we look forward to the next session"

"You are making a real difference that has a clear benefit to staff"

Priority Action 19 (2022-2023).

Relaunch our active offer of individual safeguarding supervision, along with group supervision.	September 2022

5.8 Safeguarding Ambassadors

5.8.1 Engagement with Safeguarding Ambassadors continues and further training dates for 2022-2023 are to be arranged. Corporate Safeguarding are identifying the clinical areas where there are no Ambassadors to have a targeted approach for further recruitment. Safeguarding incidents and Desktop Reviews has enabled identification the link those areas where Safeguarding Ambassadors were very sparse or had none. The Ambassadors have proven and continue to do so, to be beneficial in supporting staff in the understanding of the Adult at Risk process with appropriate signposting an escalation to the Designated Safeguarding Practitioner and Safeguarding resources.

5.8.2 BCUHB total number of Safeguarding Ambassadors is currently 147 which is an increase from 2020 – 2021 where the number was 68. This is an increase of 116%, which is above our priority action of increasing Safeguarding Ambassadors by 25%. The current Safeguarding Ambassadors can be divided into the following:

- East – 49
- Central – 54
- West – 44

5.8.3 A Conference for Safeguarding Ambassadors was held during National Safeguarding Week in November 2021. This was well attended where a total of 45 Ambassadors attended and provided incredibly positive feedback and evaluation in relation to its content and quality of the presentations. Key issues were highlighted for ambassadors to take back to their area.

Priority Action 20 (2022-2023).

Corporate Safeguarding to promote and provide further training to recruit up by 25% further Safeguarding Ambassadors for BCUHB.	March 2023

5.9 Safeguarding Bulletin

5.9.1 Corporate Safeguarding continue to produce the monthly safeguarding bulletin. This was maintained throughout the COVID-19 Pandemic. The bulletin has been capturing relevant, topical, and current issues, as well as themes and trends specific to all aspects of the safeguarding agenda. Key messages have been shared to promote the practical and theoretical perspective of safeguarding which can be translated into practice. Items within the bulletin are directly linked to current practices and include live updates and communications to inform staff across BCUHB.
One of our learning Bulletins in relation to falls and the application of safeguarding received significant positive feedback from areas and was discussed at falls groups for MHLD division as well as in area falls groups.

6 Multiagency Partnership Working

6.1 Rationale

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

6.2 Falls

6.2.1 During 2021-22, there were 4882 Datix Incidents in relation to Slips, trips, falls and collisions. This is a 4.3% decrease when compared to the 2020-21, when 5101 Datix Incidents were recorded. The continued focus on falls prevention could be a contributing factor in this initial reduction in recorded falls as much work was completed in relation to falls prevention and removing clutter from areas of high falls rates which was supported by Corporate Safeguarding Team.

6.2.2 Head of Safeguarding Adults or the Regional Safeguarding Specialist for Adults / Adults living with Dementia continue to attend Strategic Falls group and raise the profile of this within Safeguarding Forums and other governance meetings.

6.2.3 Level 1 e-learning training has been developed with colleagues at Wrexham Local Authority, Corporate Nursing and Corporate Safeguarding. This includes direction to consider safeguarding particularly during post fall review. This has been ratified and is available on ESR as a module A for everyone and Module B for clinical staff involved in falls management.

6.2.4 Members of the Corporate Safeguarding Team are co-authors of The Falls Policy referencing the Wales Safeguarding procedures.

6.2.5 Senior nursing teams, Clinical Governance and the wider MDT including corporate Safeguarding, review all falls with harm within the District General Hospital. This is within its own dedicated area meetings with community falls now also being discussed in the east area as part of their wider HARMS review process. Falls are also discussed within the MHLD division regionally. Corporate safeguarding team are a core member of these meetings and apply principles of enquiry to ensure learning is meaningful.

6.2.6 Level 2 falls training is being delivered via Manual Handling focussing on post falls management and includes direction to consider safeguarding post fall, signpost to the Designated Safeguarding Person and the Safeguarding Webpage.

6.2.7 Through desktop reviews it has been further confirmed that there remains no consistent correlation between falls reporting and adult at risk reporting. It is envisaged that the embedding of the Wales safeguarding procedures into the new falls policy and a consistent and mirrored direction in all training packages will create increased consistency in approaches taken.

6.2.8 The Safeguarding Learning Bulletin for July 2021 focussed on the correlation between falls and Safeguarding including scenarios and key messages.

6.2.9 Safeguarding continues to contribute towards the development of the Level 3 training.

6.2.10 Corporate Safeguarding to meet with Corporate Governance / Head of Quality Assurance in relation to falls and correlation to safeguarding going forward.

6.3 Multi Agency Public Protection Arrangements (MAPPA)

6.3.1 Multi Agency Public Protection Arrangements are the statutory arrangements for managing sexual and violent offenders. Multi Agency Public Protection Arrangements is not a statutory body, but it is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a coordinated manner. Agencies always retain their full statutory responsibilities and obligations.

6.3.2 The Responsible Authority (RA) consists of the Police, Prison, and Probation Services. They are charged with the duty and responsibility to ensure that Multi Agency Public Protection Arrangements is established in their area and for the assessment and management of risk of all identified Multi Agency Public Protection Arrangements offenders.

Corporate Safeguarding representatives and MHLD Divisional colleagues contribute to the identification and assessment of risk and agree a multi-agency risk management plan.

6.3.3 Attendance at Multi Agency Public Protection Arrangements is mandatory and Corporate Safeguarding have a 100% attendance rate in 2021-2022.

Table 17: **Active Multi Agency Public Protection Arrangements cases Reviewed in 2021-2022.**

Area	MAPPA 2	MAPPA 3
Central	36	1
East	68	5
West	45	3
Total	149	9

6.3.4 In total there were 149 cases reviewed at Multi Agency Public Protection Arrangements 2 and 9 cases discussed at Multi Agency Public Protection Arrangements 3. The East area had the highest number of cases discussed in 2021-2022. Corporate Safeguarding Team maintained 100% attendance at all Multi Agency Public Protection Arrangements meetings, which supports the risk management of individuals open to this forum whilst also requiring health service provision from BCUHB.

6.3.5 There are monthly Multi Agency Public Protection Arrangements 2 meetings held for the six counties across North Wales. The frequency of the Multi Agency Public Protection Arrangements 3 meetings can vary depending upon dependent on risk and need.

Multi Agency Public Protection Arrangements 2 cases must be reviewed at a minimum of 16 weeks and Multi Agency Public Protection Arrangements 3 cases reviewed every 8 weeks as a minimum. (Multi Agency Public Protection Arrangements Guidance 2021).

6.3.6 In Quarter 2 BCUHB Corporate Safeguarding Team were invited to support in a Multi Agency Public Protection Arrangements Serious case Review. The focus of this is to examine whether the Multi Agency Public Protection Arrangements were effectively applied and whether the agencies worked together to do all they reasonably could to effectively manage the risk of further offending in the community.

6.3.7 Learning from Multi Agency Public Protection Arrangements serious case review has been shared in safeguarding forums and with appropriate services directly.

6.4 Modern Day Slavery and Human Trafficking

6.4.1 Corporate Safeguarding and Public Protection represent BCUHB on Regional Partnership Boards, including the North Wales Safeguarding Boards for Adults and Children. Vulnerability and Exploitation Board (County Lines and its related Harm Agenda is incorporate into the Vulnerability and Exploitation Board) in addition to the Modern Slavery Providers Forum. Corporate Safeguarding.

6.4.2 BCUHB provides services in line with the Social Services and Wellbeing (Wales) Act 2014, Serious Crime Act 2015, and other key legislation.

6.4.3 As an organisation BCUHB provides NHS provision in accordance with statutory legislation and is a provider and commissioner of services. This includes mental health/substance misuse and healthcare and treatment both in primary, community, and secondary care services for the victims of Modern Slavery.

6.4.4 With regards to Modern Slavery and all Safeguarding Concerns, Safeguarding and Public Protection within the Health Board is provided by a specialist team and consists of the following:

- The provision of Safeguarding advice.
- The implementation of Safeguarding legislation and guidance.
- Provides scrutiny and Quality and Governance within the Safeguarding arena.
- Development and implementation of Policies and Procedures/guidance specific to the NHS.
- Development and implementation of Training both mandatory and bespoke.
- Engagement and participation with partners and partner agencies on a multi-agency platform, Regional and National.

6.4.5 Training is mandatory for level 1 and 2 Adults at Risk and Children at Risk and also Mental Capacity Act level 1 and 2. This follows the NHS

Intercollegiate Documents for Health Care staff. Level 3 training is also provided in both Adults and Children which includes detailed information in relation to Modern Day Slavery.

6.4.6 Corporate Safeguarding Team attend Multi Agency Risk Assessment Conference Modern Day Slavery strategy meetings and all other safeguarding strategy meetings held under the Adult and Child at Risk legal framework.

6.4.7 Safeguarding Supervision is provided to practitioners who work within Adult and/ or Children services (this includes Mental Health Learning Disabilities and CAMHS. These supervision sessions can be on a one-to-one basis or within a group. Modern Day Slavery is incorporated into the sessions as well as other wider harm subjects.

6.4.8 Local Response to Ukrainian Refugees is also discussed at the Modern Slavery Forum. A regional Group is established within BCUHB which Corporate Safeguarding attends to support from Modern Slavery, Human Trafficking and Exploitation perspective.

6.5 Prevent

6.5.1 On behalf of BCUHB, the Director of Safeguarding and Public Protection attends the CONTEST Board. Head of Safeguarding Adults attends All Wales PREVENT meetings to receive regular updates from the Welsh Extremism and Counter Terrorism Unit. BCUHB has a perfect attendance record.

6.5.2 Although a suspect package was found at Ysbyty Maelor Wrexham, this turned out to be a false alarm. However there has been terrorism activity in the UK in the last 12 months increasing the threat level that currently reported as SUBSTANTIAL.

The threat levels are designed to give a broad indication of the likelihood of a terrorist attack.

- LOW means an attack is highly unlikely.
- MODERATE means an attack is possible, but not likely.
- SUBSTANTIAL means an attack is likely.
- SEVERE means an attack is highly likely.
- CRITICAL means an attack is highly likely in the near future.

6.5.3 Corporate Safeguarding are work collaboratively and proactively with the Associate Director of Occupational Health Safety And Security and his team in relation to security in addition to the Head Of Emergency Preparedness & Resilience, Planning.

6.5.4 A BCUHB Bomb Threat and Suspect Package Policy has been developed with consideration to Corporate Safeguarding Team involvement within the Policy.

6.5.5 An SBAR has been submitted to request that Home Office E learning is Mandatory to all BCUHB staff. This will be reported to the PSQG.

6.6 Advocacy

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

6.6.2 A priority for 2020-2021 was to engage and support commissioning services to review the contract for the advocacy service. This was initiated in Quarter 2 where the Head of Safeguarding Adults MHLD was an active part of the commissioning providing expectations in relation to their responsibility in relation to Safeguarding.

6.7 Patient Experience

6.7.1 Corporate Safeguarding Team within Quarter 4 have been further developing relationship with the Patient Advice and Liaison Service (PALS). This is becoming a positive bilateral relationship where Corporate Safeguarding Team are providing support to the Patient Advice and Liaison Service in relation to identifying Adult at Risk and wider safeguarding concerns. Corporate Safeguarding Team are able to further learn directly from the individual or their carer/representative which further enhances training and supervision.

Priority Action 21 (2022-2023).

Coordinate Quarterly Safeguarding Supervision with PALS team and embed learning from patient stories into Safeguarding Bulletin and 7-minute briefings so as this can be shared widely	September 2022

6.8 Patient Story

6.8.1 The patient story of MD was shared with Corporate Safeguarding team by the Patient Advice and Liaison Service during an initial supervision session, as they believed this was a story personal to Mr D but with shared themes from other people's experiences. It also highlights several of the key priorities for Corporate Safeguarding for 2022-2023.

6.8.2 Overview of story

"I am an unpaid carer for my mum suffers who has severe mixed dementia. My mum cannot go anywhere on her own at all so, when she was admitted to hospital by ambulance with chest pain and vomiting, I drove to the hospital to accompany her.

Whilst we were in the hospital, I felt that my mum was ignored for hours and no support was offered to help her, or me as her carer. Staff did not seem to acknowledge her dementia diagnosis and showed no awareness that her being left for many hours with no treatment would escalate her agitation. I was left to deal with her extremely distressed state alone, with very little support from staff. Although I repeatedly asked for a butterfly to be put above her bed, to indicate to staff that my mum had dementia, this was never done.

Also, a very important letter that I must carry with me to explain my mum's dementia diagnosis was lost whilst my mum was in hospital, and I had to request that another one be sent to me by her psychiatrist.

More robust dementia awareness training needs to be put in place to ensure all staff are aware of how to recognise and deal with dementia patients. The Butterfly Scheme needs to be implemented in the Emergency Department and the butterfly symbol should be supplied above the bed and on the notes of all dementia patients as a signifier to staff that they are dealing with a dementia patient".

6.8.3 **Key message**

It is appreciated that there can be delays within the Emergency Department due to the demand and capacity issues. This can result in long wait in Emergency Department for elderly patient who have little communication or support offered to them – Corporate Safeguarding Team are working closely with Emergency Department across BCUHB to implement positive practices to improve the experience for people living with dementia, this has included:

- orientation clocks.
- reduced clutter.
- dementia friendly signage.
- raising the profile of those people living with dementia and their carers.
- Benchmarking of good/ best practice.

6.8.4 **Learning**

Patient's dementia diagnosis was not considered, and patient was left for a long time without treatment - Supporting the person not the problem is a mantra to have in all agencies. Corporate Safeguarding Team have commissioned production of a brief dementia pocket guide for ward-based staff to follow.

Patient's carer was not acknowledged or supported - Corporate Safeguarding team are supporting the reintroduction of John's Campaign and sharing its purpose.

Butterfly scheme was not implemented in the Emergency Department – Corporate Safeguarding team have been actively engaged in the development of the Wales Dementia Friendly Hospital Charter which not only looks at embedding the identification scheme whether that be Butterfly or Daisy but also further must take actions to support the well-being of the person living with dementia and their carer in our hospital environments. The roll out of this will be Q3 and Q4 of 2022-2023 but in the interim the Corporate Safeguarding Team will support the Dementia Consultant Nurse to begin to explore and embed the principles into practice.

Appendix 2

Corporate Safeguarding Annual Report - Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) 2020-2021

1. Introduction

1.1 This report (April 2021 – March 2022) provides an overview of progress made in relation to the activities and priority actions highlighted in the Six-Month Report for 2021-2022.

1.2 This report specifically relates to the three areas, Safeguarding Children at Risk, Safeguarding Midwifery and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV).

1.3 The reporting framework is based using the five (5) key domains of the National Safeguarding Maturity Matrix (SMM).

2. Governance and Rights Based Approach

Rationale

2.1 There should be a clear line of accountability, without doubt or ambiguity about who is responsible at every level for the well-being and protection of children. The United Nation's Convention on the Rights of the Child states that children should be free from abuse, victimisation and exploitation. The environments where children are treated should be safe, secure and child friendly.

Safeguarding Children at Risk

2.2 Safeguarding Maturity Matrix (SMM)

2.2.1 The Safeguarding Maturity Matrix is a quality outcome monitoring tool with the aim of capturing and collating a national Safeguarding Maturity Matrix providing assurance, shared practice and drive improvements towards a 'Once for Wales' consistent approach to safeguarding.

2.2.2 The Safeguarding Maturity Matrix is a self-assessment of safeguarding arrangements by each Health Board/Trust. The five standards assessed are Governance and Rights Based Approach, Safe Care, Adverse Childhood Experiences Informed, Learning Culture and Multi Agency Partnership Working. The highest achievable score is five (5) for each standard giving a total score of twenty-five (25).

2.2.3 BCUHB achieved a score of Fourteen (14) in 2018, a score of Twenty-three (23) in 2019 and a score of Twenty-five (25) in 2020 and 2021. This demonstrates excellent continued and consistent progress and is achieved by evidencing service quality improvements, full engagement in multi-agency arrangements and demonstrating good examples of evidenced based learning.

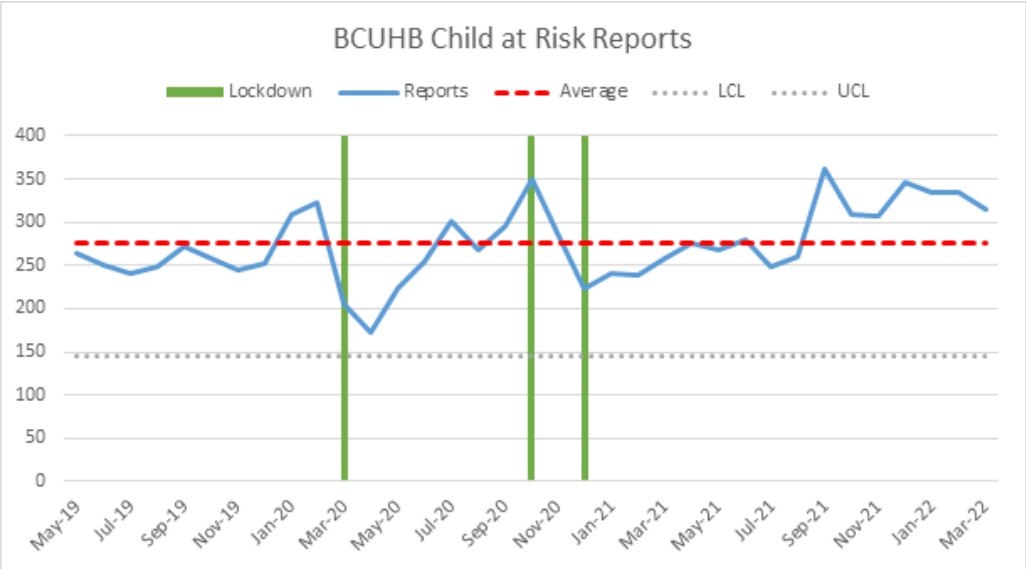
2.2.4 By contributing to this work BCUHB can inform the national picture report through the NHS Safeguarding Network to the Chief Nursing Officer in Welsh Government.

2.2.5 In 2021-2022, an All-Wales Task and Finish Group was developed to review the Safeguarding Maturity Matrix to ensure it remains fit for purpose.

2.3 Children at Risk Performance Reporting

2.3.1 In 2021-22, the Corporate Safeguarding Team received 3642 Child at Risk reports. This is a significant increase of 17% when compared to the 3116 Child at Risk reports received during 2020-21.

Figure 1: Child at Risk Reports (May 2019 – March 2022) with the Welsh Government COVID-19 lockdowns indicated.



2.3.2 Figure 1 highlights the impact of COVID-19 and the national restrictions / lockdowns implemented by the UK and Welsh Government. Reductions in Child at Risk reports are primarily attributed to the impact upon staffing and service delivery in conjunction with the national guidance in place at that time. For this reporting year, Figure 1 demonstrates a rise in reports against the organisations average, with peaks in September and December 2021. A dip in reporting was observed in July and August 2021 which coincides with children and young people being absent from school for the summer holidays.

2.3.3 There was a significant increase in reporting rates in September 2021 this is attributed to the submission of retrospective reports. Some reports had only been submitted to the Local Authority at the time of initial reporting. This was addressed by the Area Nurse Directors BCUHB wide communication highlighting the correct process. The issue will be logged for discussion at Area Safeguarding Forums and escalated as an alert to the Safeguarding Governance and Performance Group if required.

Table 1: **Child at Risk reports per 10,000 under 18 population.**

2021-2022	Under 18 Population	Reports	Reports per 10,000 Under 18
West	36,553	596	163.1
Central	40,683	1059	260.3
East	61,112	1928	315.5

2.3.4 The East area has the highest number of Child at Risk reporting as demonstrated in Table 2, the reports per 10,000 children is considerably higher than the West and Central areas which is consistent with last year's statistics. This in part can be attributed to population size of under 18-year-olds.

2.4 Reports by Location and Report-Makers Designation

Table 2: **Child at Risk reports by Designation of referrer.**

Designation of Referrer	Reports	Proportion of Reports
Emergency Department	906	24.9%
Other	759	20.8%
Health Visitor	666	18.3%
Midwife	566	15.5%
Child Adolescent Mental Health Service (CAMHS)	423	11.6%
School Nurse	107	2.9%
General Practitioner	84	2.3%
Children's Ward	74	2%
Substance Misuse Service (SMS)	46	1.3%
Not Recorded	11	0.3%

2.4.1 Emergency Department (ED) staff continue to submit the highest number of reports accounting for 24.9% of all reports. The 'other' category accounts for 20.8% and these cover a very wide spectrum of services.

2.4.2 This suggests that additional training and supervision may be required in these areas, and this will be addressed as a priority activity in Q1 & Q2 2022-2023.

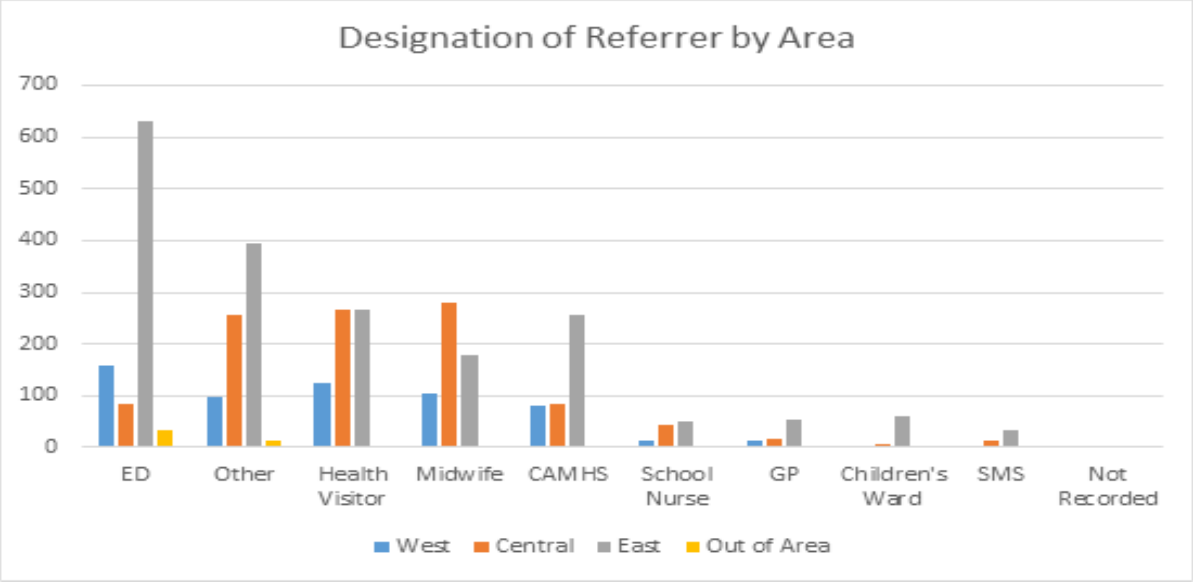
Table 3: **Reports with the outcome recorded as more information required by designation of referrer.**

Designation of Referrer	2021-2022				Total	%
	Q1	Q2	Q3	Q4		
Other	4	25	18	17	**64**	31.5%
CAMHS	2	8	9	10	**29**	14.3%
ED	7	11	4	6	**28**	13.8%
Health Visitor	6	7	7	8	**28**	13.8%
GP	1	7	6	5	**19**	9.4%
Midwife	4	6	6	2	**18**	8.9%
SMS	2	2	1	3	**8**	3.9%
School Nurse	2	2	2	0	**6**	3.0%
Children's Ward	0	1	1	0	**2**	1.0%
GP and HV	0	1	0	0	**1**	0.5%
Total	**28**	**70**	**54**	**51**	**203**	

2.4.3 53.3% of reports that recorded the outcome as No Further Action, were submitted from Emergency Department. This highlights a significant percentage and may be an indicator of over reporting. The safeguarding team will continue to monitor this as part of registered audit activity and reports will be produced to reflect the findings.

2.4.4 There is a live Emergency Department Improvement Action Plan which incorporates monitoring an auditing of Child at Risk reports and this is under weekly review. Each Child at Risk report is reviewed by the Safeguarding Liaison Specialists. Inferior quality reports are addressed at source through supervision and signposting to additional training. Report writing forms part of the Safeguarding Mandatory Training packages.

Figure 2: Child at Risk reports by Area.

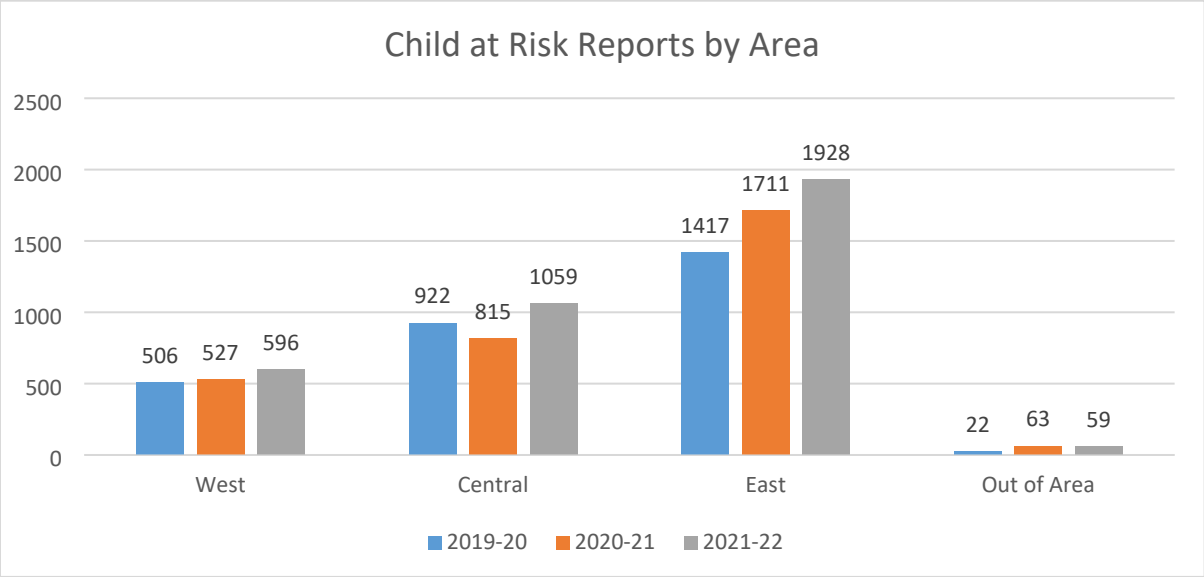


2.4.5 The highest referrers of Child at Risk reports during 2021-2022 are the Emergency Department. This replicates the trend we saw in 2020-21. As highlighted above a significant percentage of reports were submitted from Ysbyty Wrexham Maelor Emergency Department. 32.7% (n=630) of Child at Risk reports from the East were submitted by the Emergency Department.

Similarly, to the East, the Emergency Department in Ysbyty Gwynedd submitted the highest proportion of reports in the West.

In contrast, the Emergency department generated only 8% of reports from the Central area, with midwives being responsible for the highest proportion of reports (26.4%) in the Central area.

Figure 3: Child at Risk Reports by Area, 2019-2022.



2.4.6 Figure 3 demonstrates that all three areas of BCUHB have seen a year-on-year increase in the number of reports. Central had the most significant increase in Child at Risk Reports evidenced by the 30% uplift from 2020-2021 to 2021-2022.

2.4.7 The Corporate Safeguarding Team have supported the introduction of the Wales Safeguarding Procedures through additional training and supervision. The increased reporting rates may be attributed to this in addition the reduction of COVID-19 restrictions making children more visible to services.

2.5 Child at Risk reports by age group.

Table 4: **Child at Risk reports by Age Group.**

Age Group	Unborn	<5	5-10	11-15	16-18	Not Known	Total
2020-2021	415	1006	494	711	407	83	3116
2021-22	488	1163	482	943	437	129	3642

2.5.1 The age group with the highest number of reports (32%) is the under 5s and this is consistent across all the areas. When combined with Unborn's this makes up 45% of all Child at Risk reports submitted by BCUHB.

2.5.2 The age group within this reporting timeframe with the largest increase of reports compared to 2020-2021 was 11-15. This saw an increase of 33% and correlates with high-risk complex cases of young people presenting with mental health issues and emotional dysregulation.

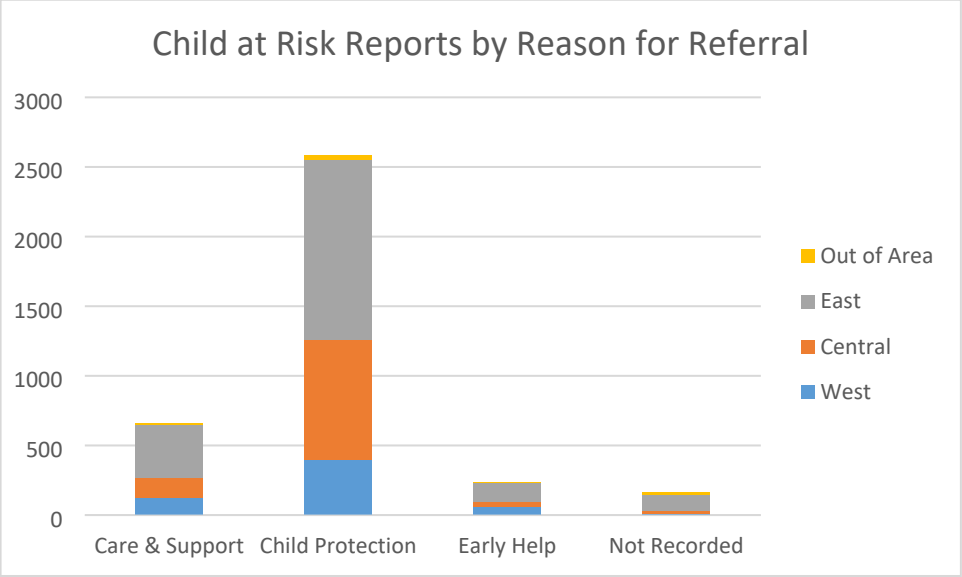
2.6 Themes of Abuse

2.6.1 Where themes of abuse have been recorded in the first half of 2021-2022, the most prevalent type of alleged abuse is emotional, existing in almost a quarter of all Child at Risk reports submitted. Neglect accounts for over 17% of reports and physical abuse is recorded in 10% of reports.

2.6.2 It must be noted that almost 43% of reports have no theme of abuse recorded. The recording of themes needs to be improved across the region so that intervention can be targeted, and needs led. A priority action will be to undertake an audit of the Child at Risk database to monitor themes and trends which will inform future practice, training and best outcome for Child and young people.

2.7 Reason for referral

Figure 4: Child at Risk reports by Reason for Referral.



2.7.1 Figure 4 above indicates the most predominant reason for a report to be completed. Therefore, there is clear evidence that threshold for harm or concerns has been met.

2.7.2 The West area by proportion of all child at risk reports makes more reports for early help and care and support than the other two areas.

2.8 Outcome of Child at Risk Reports

Table 5: **Child at Risk reports outcomes by Local Authority Area.**

Area	Outcome			
	Outcome Received	Outcome Outstanding	Total	% of outcome received
Ynys Mon	93	196	289	32.2%
Gwynedd	122	185	307	39.7%
Conwy	1	399	400	0.3%
Denbighshire	71	588	659	10.8%
Flintshire	612	224	836	73.2%
Wrexham	180	912	1092	16.5%
Out of Area	7	52	59	11.9%
Total	**1086**	**2556**	**3642**	**29.8%**

2.8.1 Of the 1086 outcomes received, 334 (30.8%) were closed with no further action. In the period 2021-2022 this was 30%. The percentage remains almost static, however this is a high percentage which needs to be reviewed. It may be an indicator of over reporting and or poor-quality reports which are not providing detailed information to support safe decision making.

2.8.2 The Head of Safeguarding has formally raised the matter of lack of outcomes data with the North Wales Heads of Children's Services. This is Continuing piece of strategic partnership work that will continue in Q1 (2022-2023). Were data will be reviewed in partnership with the relevant local authorities. Escalation to North Wales Safeguarding Board if Outcome data continues to cause concern.

2.9 Audit of Child at Risk Reports

2.9.1 The audit commenced in April 2021 and consists of five reports a month selected randomly. This process is completed by Children's safeguarding specialists across each Area, Central, East and West along with Safeguarding Midwifery specialists across the region.
Reports are rated as Excellent, Good, Average or Poor.

Excellent - To achieve an excellent score at least 14 domains need to have been achieved or rationale as to why not required.

Good - To achieve a good score at least 10 domains need to have been achieved or rationale as to why not required.

Average - To achieve an average score at least 8 domains need to have been achieved or rationale as to why not required.

Poor - If less than 8 domains have been achieved the score should be recorded as poor.

Table 6: **Evaluation scores per area.**

Area	Excellent	Good	Average	Poor
East	11	5	5	9
Central	8	15	4	3
West	8	9	11	2

2.9.2 As all Child at Risk reports are reviewed by a Safeguarding Children's Specialists, timely feedback can be offered to the referrer. Immediate safeguards can be addressed at source and any additional training and supervision required can be arranged.

2.9.3 There have been specific supervision sessions held in each area within Emergency Departments to help increase awareness of the expected standard. This has been in a cascade model with Matrons and the Leadership Team which allows for common practice concerns to be highlighted with the team in safety brief/safety summit.

2.9.4 Following completion of the Child at Risk audit a report will be constructed offering an overview of its findings and highlighting areas of good practice and areas where additional work is required. This will be set as a priority activity for 2022-2023.

Priority Action 22a & 22b Children at Risk (2022-2023).

a) Conduct a larger scale regional retrospective audit of the quality of Child at Risk Reports Q3 & Q4.	March 2023
b) Quarterly Audit of Child at Risk Reports and findings report/action plan 2022-2023.	April 2023 Final Report

2.10 Section 47 Child Protection (CP) Medical Examinations

2.10.1 239 Child Protection Medical Examinations have taken place across BCUHB during 2021-2022. This is a 5% increase in comparison to the 227 examinations conducted during 2020-2021.

2.10.2 The data below also includes children and young people from outside the area who has had an examination within BCUHB.

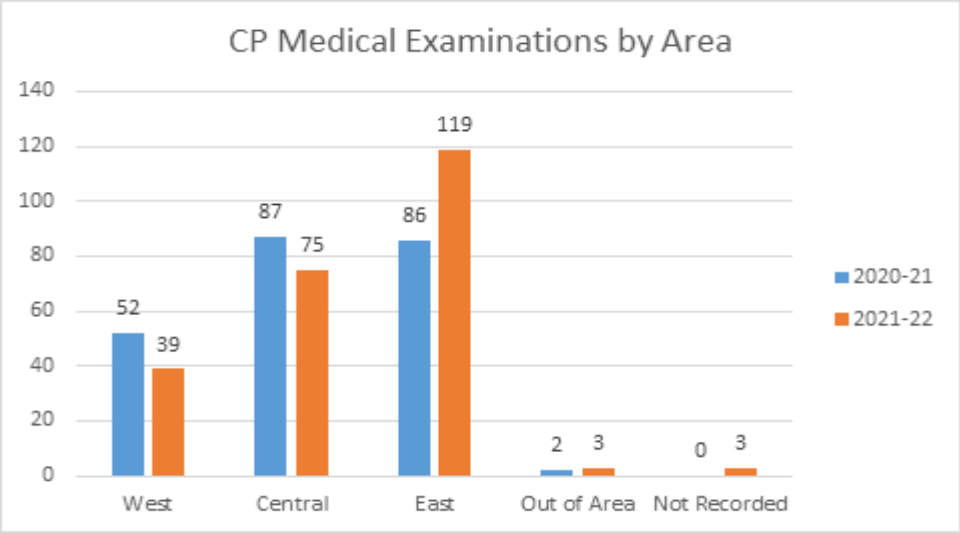
Table 7: **Child Protection Medical Examinations by Year.**

Year	Examinations
2016-17	296
2017-18	273
2018-19	259
2019-20	277
2020-21	227
2021-22	239

2.10.3 When reviewing the examinations that have taken place during 2021-22, we find that the East area has been the location of the most examinations accounting for 50% (n=119).

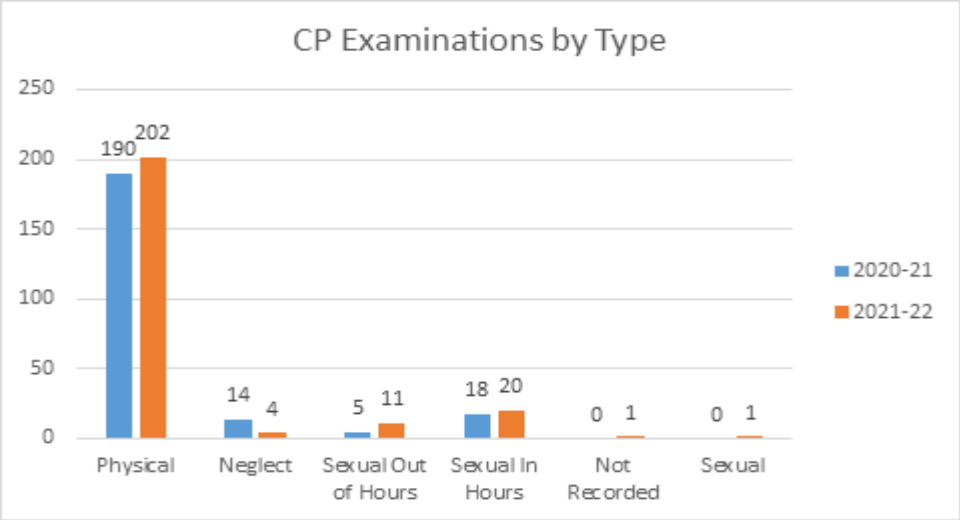
2.10.4 Both the West and the Centre have seen a decrease in the number of examinations during 2021-2022 when compared to last year, with the West recording the fewest examinations of the three areas of BCUHB overall.

Figure 5: Child Protection Medical Examinations by Area.



2.10.5 Suspected physical abuse continues to be the most prominent reason for examinations as demonstrated in the graph below. From Figure 6 below, we can see that the number of both physical and sexual abuse cases has increase in 2021-2022 and the number of neglect cases has decreased.

Figure 6: Child Protection Medical Examinations by alleged abuse type.



2.11 Child Protection Peer Review Meetings

2.11.1 The monthly Peer Review meetings continue to take place in each of three Hospital sites across the Health Board. All Paediatricians (Community and Hospital) are invited to attend. Each case is reviewed and uploaded onto a shared drive. This is to facilitate the sharing of learning across BCUHB.

2.11.2 Since the COVID-19 arrangements have been in place meetings have been held virtually and attendance has improved. The meetings continue to be held virtually at the time of report.

2.12 Safeguarding Children Supervision Sessions

2.12.1 As an organisation BCUHB is committed to ensuring that both supervisors and supervisees are clear about their roles, responsibilities, and accountabilities in relation to the protection of children, adults and their families. Safeguarding Supervision continues to be provided in line with the Safeguarding Supervision Procedure SCH01.

2.12.2 There are four types of recognised safeguarding supervision:

- Individual (one-to-one) supervision.
- Group supervision involving a team, or a group of different disciplines.
- Telephone advice / consultation.
- Face to face supervision.

2.12.3 Newly qualified or newly appointed health visitors, school nurses and midwives working with children (including unborns) are offered supervision with the identified Safeguarding Specialist initially on a monthly basis. The frequency of this is then reassessed in accordance with the clinician's competence which will be agreed between the supervisor and supervisee.

2.12.4 Practitioners returning from long term leave must participate with supervision within the first month of returning to practice.

2.12.5 All caseload holders for children, including school nurses, health visitors, community midwives and Child Adolescent Mental Health Service Practitioners will actively engage with one-to-one supervision six monthly as a minimum.

Responsive Supervision

2.12.6 The Safeguarding Team are available to support BCUHB employees should they wish to discuss a safeguarding concern or reflect on recent practice. The supervision is available on demand, and it may be over the telephone, face to face, individual or in a group setting.

2.12.7 The mode of supervision will be agreed between the supervisor and supervisee according to identified need. This may also be initiated by the Corporate Safeguarding Team if required to support active cases, reflective learning and as necessary initiate activity for the purpose of reducing risk and potential harm.

2.12.8 A record of agreed actions will be made on the 'Record of Discussion'.

2.12.9 Table 9 highlights the data in relation to supervision. 100% compliance has not been achieved across the region. The challenges have been in part due to staff redeployment and long-term sickness. There has also been long-term sickness and vacant caseloads within the Corporate Safeguarding Team which has resulted in some supervisions not being completed within policy timescales. Compliance rates in the West were particularly low in Q4, this was due to long term sickness, maternity leave and redeployment in the teams. Two sessions were postponed by the Safeguarding Team due to COVID-19 related staff sickness.

Table 8: **Regional Supervision Data**

	Numbers (Compliance %)							
	Mode of Supervision							
	Individual Supervision				Group Supervision			
Area	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Wrexham	32 (93%)	12 (90%)	41 (91%)	42 (93%)	2	2	5	0
Flintshire	53 (93.6%)	44 (95%)	37 (89.6%)	36 (88%)	2	2	3	0
Conwy	22 (91%)	3 (73%)	23 (94%)	12 (96%)	2	1	2	1
Denbighshire	10 (65%)	8 (75%)	21 (85%)	16 (92%)	1	2	1	2
Anglesey	11 (89%)	9 (90%)	10 (95%)	10 (91%)	1	2	1	1
Gwynedd	25 (79%)	21 (98%)	30 (90%)	10 (59%)	1	2	1	1

2.12.10 Topics of discussion have included.

- Parental mental health issues.
- Parental substance misuse.
- Young Person mental health issues.
- Domestic abuse.

These discussions have been linked to cases and facilitated the sharing of good practice and lessons learnt. Changes in practise and any current new legislation are also discussed.

2.12.11 A continuing theme within safeguarding supervision is the on-going constraints to the school nursing service. Safeguarding commitments remain high with practitioners having high numbers of children on the child protection register and or with local authority involvement. The school nursing service report that they are receiving an escalating number of children presenting with mental health concerns requiring enhanced intervention and service. Ad-hoc supervision continues as required and is delivered via telephone and Teams. Band 5 School Nurses have been offered supervision and these sessions have been arranged for Q1 and Q2 2022-2023.

2.12.12 Supervision prior to March 2022 was provided both face to face and via telephone and teams. The majority was provided via teams due to the ongoing COVID-19 arrangements. Telephone advice is ongoing. As the COVID-19 restrictions are being relaxed the aim for 2022-2023 to re-establish more face-to-face sessions. These however will be risk assessed prior to being undertaken to ensure staff safety.

2.12.13 The Liaison Specialists have maintained a presence in the emergency Departments and paediatric wards throughout 2021-2022. The COVID-19 restrictions did have an impact on accessing the clinical areas.

The COVID-19 status of the ward and the Personal Protective Equipment Requirements for the area were assessed before staff accessed them.

2.12.14 There will be increased supervision and face to face contact delivered by corporate Safeguarding as part of the ongoing Emergency Department Action Plans.

2.13 Group Supervision

2.13.1 Group supervision sessions are delivered in addition to and not instead of individual supervision. These sessions provide the opportunity for all attendees to discuss/share situations which may have been causing concern, or which may have gone well, or to critically look at scenarios.

2.13.2 Group supervision also provides an arena for reflective learning, training and supporting newly qualified and inexperienced professionals.

2.13.3 Group supervision is facilitated by the Safeguarding Specialist. The sessions are open to all staff and dates are available on the Safeguarding Webpage. If additional teams wish to arrange a supervision session, they can contact the Safeguarding Team in their area.

2.13.4 Sessions also provide an opportunity for the Safeguarding Team to update staff on any new developments within the safeguarding arena. The sessions also provide an opportunity to invite multi-agency specialist practitioners to discuss their roles in Safeguarding, thereby illustrating the importance of effective multi-agency communication and working together in order to safeguard children at risk of harm.

2.13.5 A record of attendees is held by Corporate Safeguarding. During the reporting timeframe there has been a focus on the following safeguarding themes:

- Wales Safeguarding Procedures (2019).
- Domestic Abuse and the Multi Agency Risk Assessment Conference.
- Abolition of Reasonable Punishment Act.
- Lessons Learnt from Practice Reviews.
- Substance Misuse and Mental Health.
- Child Exploitation.
- Child at Risk Reports and themes during COVID-19.
- Professional Curiosity.

2.13.6 There have been Thirty-Seven (37) Safeguarding children supervision sessions provided in this reporting period across the region. There has been total of 535 attendees.

2.13.7 All group sessions undertaken have been delivered virtually in line with COVID-19 guidance.

2.13.8 Feedback from Safeguarding Children group supervision is reported below as an average for each question out of a possible five (5):

- The session met my expectations and was relevant to my area of work – 4.7.

- The facilitator was able to promote the inclusion of those in attendance and encourage participation – 4.8.
- Participants were able to set the agenda and drive discussion – 4.5.
- The facilitator was able to answer questions clearly with expertise – 4.8.
- Group supervision enhances my ability to be an effective practitioner – 4.7.

2.14 Children (Abolition of Defence of Reasonable Punishment (Wales) Act 2020

2.14.1 The legislation gained Royal Assent and became an Act on the 20th of March 2020. The Act was implemented on the 21st of March 2022. This Act removes the defence of reasonable punishment if cases reach court.

2.14.2 The Head of Safeguarding Children attends the National Operation, Guidance and Training Group, looking at reviewing processes and updating guidance/training within organisations.

2.14.3 A Strategic Implementation Group with supporting working groups were developed to drive this agenda forward, ensuring BCUHB will be compliant with their statutory duties. A target date for completion of the work was February 2022 and this deadline was met.

2.15 Ward Accreditation

2.15.1 Corporate Safeguarding continue to provide safeguarding reports to assist in the Accreditation process.

2.15.2 Corporate Safeguarding have completed two (2) reports for Children's wards during 2021-2022. These reports highlight good safeguarding practice in addition to offering recommendations for improvement as required.

2.15.3 In October 2020, a Guidance was developed to support the process of sharing safeguarding information supporting the Ward Accreditation Reviewers in their assessment.

2.16 Procedure for the Safeguarding of Children and Young People Admitted to Adult-Based Wards and Environments

2.16.1 Across BCUHB children and young people are admitted to adult-based wards and environments for various medical and surgical assessments/interventions. In 2020, a review highlighted a total of 600 children and young people were admitted.

2.16.2 The procedure ensures the health and well-being of children and young people, up to the age of 18 years, is promoted and safeguarded when they are cared for within what is traditionally viewed as adult-based wards and environments, across BCUHB.

2.16.3 The aim of the procedure is to gain assurance all health practitioners understand their role and responsibilities and provide guidance on identifying and escalating risks relating to Children and Young People on adult-based wards and environments.

2.16.4 The procedure has been ratified at Patient Safety and Quality Group in Q2 and implemented. Quarterly audits by the Secondary Care Directorate will take place to monitor compliance.

3. Adverse Childhood Experiences (ACE) Informed

Rationale

3.1 Adverse Childhood Experiences such as exposure to abuse and harm, for example, sexual abuse, psychological/emotional abuse, physical abuse, domestic abuse, substance misuse and mental illness are known to have a direct and immediate effect on a child's health and wellbeing with potential lifelong consequences.

3.2 The safety of the child and the safety of the vulnerable adult with care giving responsibilities are intrinsically linked. Preventing early exposure can reduce the impact on children and future generations**.**

3.3 Looked After Children (LAC)

3.3.1 The accountability and portfolio for the Looked After Children Service sits within the Children's Division and outside of the Corporate Safeguarding Team. The Head of Safeguarding Children attends the quarterly Looked After Children Team meetings to share up to date knowledge/good practice and learning regarding safeguarding. This ensures good two-way communication between both services.

3.4 Safeguarding Supervision data

3.4.1 The standard agreed for Looked After Children Nurses is that they attend six monthly safeguarding supervision and have access to all group supervision sessions. Supervision Compliance Data is 100% for Looked After Children nurses. Safeguarding continues to support and ensure best outcomes for Children and young people as part of BCUHB corporate parenting responsibilities.

3.5 Exploitation and Child Sexual Abuse

3.5.1 There are no current Child Sexual Exploitation Operations taking place across North Wales.

3.5.2 In light of Section 6, Wales Safeguarding Procedures, the All-Wales Practice Guidance on Child Sexual Exploitation, a Regional Safeguarding Children Board Task and Finish Group is in place, to consider the implementation of a regional Child Sexual Exploitation Screening Tool. This will provide consistency across all partner agencies in the identification of Child Sexual Exploitation in Children and Young People.

3.5.3 The National Child Sexual Exploitation Action Plan and the Tackling Child Sexual Abuse Strategy (2021) remains a priority action of the Regional Safeguarding Children Board will full engagement from BCUHB.

3.5.4 A Multi-Agency Regional Child Sexual Abuse Action Plan is to be developed hosted by the Regional Safeguarding Children Board and a full evaluation will take place by the Centre of Expertise on Child Sexual Abuse with commitment and engagement from BCUHB and their partners.

3.5.6 Members of BCUHB Corporate Safeguarding Team completed a 10-month Child Sexual Abuse Practice Lead Course and are developing an Action Plan to raise awareness for BCUHB staff. A Child Sexual Abuse Training package is also being developed. A Child Sexual Abuse presentation was delivered during National Safeguarding Week.

3.5.7 Safeguarding Specialists continue to attend the Child Sexual Exploitation panels across the region and contribute to the risk mitigation plans.

3.5.8 Child Sexual Exploitation remains a standard topic within the Safeguarding Mandatory Training Plan and has been revised to reflect the Wales Safeguarding Procedures.

4. Learning Culture

Rationale

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

4. Training

4.1.1 Safeguarding training compliance data is obtained monthly from the Electronic Staff Record to review and monitor the safeguarding compliance across the health board in all safeguarding modules. A blended methodology continues to work well in the current climate and Corporate Safeguarding continue to monitor the situation and review accordingly.

4.1.2 Risk Register – ID 3756 highlights that Safeguarding Level 3 training competencies are still not linked to individual staff on Electronic Staff Record. Therefore, this results in false assurance in the accuracy of compliance data reported to the Board.

Corporate Safeguarding and Workforce and Organisational Development can now access risks: Risk ID 3759 (safeguarding) and Risk ID 4196 (Workforce and Organisational Development). Corporate Safeguarding have requested a meeting with Workforce and Organisational Development to discuss if they can provide assurance and timeframes in relation to attaching Level 3 safeguarding training competencies to individual staff on Electronic Staff Record.

4.1.3 Level 3 training compliance is reported within Level 2 and this process is managed by the training team within Workforce and Organisational Development. As Level 3 cannot be accurately reported Corporate Safeguarding have added this to the risk register.

4.2 Training Compliance

Table 9: **March 2022 Safeguarding Training Compliance by Area and Subject.**

Area March-22 Compliance	West	Central	East
Children – Level 1	80.1%	76.6%	81.1%
Children – Level 2	76.1%	75.1%	77.8%
Average Area Compliance	77.1%	75.8%	78.3%
Compliance Trend	↓	↔	↑

- The East area has the highest overall compliance of the three areas.
- Although the West is showing a decrease, the reduction in compliance is minimal. Table 10 highlights safeguarding compliance by area as a comparison from March 2021 to March 2022.

Table 10: **BCUHB Safeguarding Training Compliance by Module.**

Safeguarding Module	March 2021	March 2022	Trajectory
Safeguarding Children – Level 1	76.3%	77.4%	↑
Safeguarding Children – Level 2	74.8%	73.7%	↓

- Level 3 has seen a slight decrease. This linked COVID-19 pressures across the health board.

4.2.1 Emergency Departments Training Compliance

Table 11: **March 2022**

ED March-22 Compliance	Staff	Children's – Level 1	Children's – Level 2	Trend
YG Medical	52	78.8%	48.7%	↓
YG Nursing	69	88.4%	67.7%	↓
YGC Medical	39	59.0%	50.0%	↑
YGC Nursing	96	69.8%	81.6%	↑
WMH Medical	36	58.3%	78.0%	↑
WMH Nursing	108	86.1%	87.0%	↑

- Ysbyty Gwynedd medical and nursing staff have seen a decrease in overall compliance. However, the reduction in compliance for nursing staff is minimal.
- Ysbyty Glan Clwyd medical and nursing staff have seen an improvement with nursing staff seeing their overall compliance rise of 10 percentage points.
- Ysbyty Maelor medical and nursing staff have also seen an improvement during Q4 with nursing staff reaching the BCUHB target of 85%.

4.2.2 BCUHB Managed GP Practices

Table 12: **March 2022 Safeguarding Training Compliance BCUHB Managed GP Practices.**

March 22 Compliance GP	Area	Children – Level 1	Children – Level 2
Canolfa Goffa Ffestiniog	West	63.2%	62.5%
Longford House Surgery	West	66.7%	66.7%
Criccieth Surgery	West	68.4%	70.0%
Cambria Surgery	West	61.5%	66.7%
Porthmadog Health Surgery	West	78.6%	50.0%
Rhoslan Surgery	Central	21.1%	30.0%
Healthy Prestatyn Iach	Central	79.3%	71.8%
Rysseldene	Central	60.0%	40.0%
Llys Meddyg	Central	0.0%	0.0%
Meddygfa Gyffin	Central	100.0%	0.0%
Beechley Medical Centre	East	50.0%	66.7%
Pen y Maes Health Centre	East	83.3%	100.0%
The Laurels Surgery	East	53.8%	100.0%
Hillcrest	East	57.5%	60.0%
St Mark's Dee View Surgery	East	82.4%	88.9%
Panton Surgery	East	64.3%	66.7%

- Table 12 highlights that Safeguarding Training compliance continues to be an area of concern for most of the GP BCUHB Managed Practices.
- However, some practices are achieving above the BCUHB target of 85% compliance in some Safeguarding Modules.

This data indicates that there needs to be focused action plan as key priority across 2022-2023. To work ensure there is positive increase and compliance. Safeguarding will work with Primary Care leads to ensure this implemented and monitored across the forthcoming reporting period of 2022-2023.

Table 13

July 22 Compliance GP	Area	Children – Level 1	Children – Level 2
Blaenau Ffestiniog Surgery (B205)	West	81.0%	77.8%
Cambria Surgery (B291)	West	62.1%	57.1%
Criccieth Surgery (B227)	West	73.3%	77.8%
Longford House, Holyhead (B294)	West	70.0%	66.7%
Porthmadog (B202)	West	60.0%	50.0%
Healthy Prestatyn (B152)	Central	78.3%	71.1%
Llys Meddyg (B116)	Central	0.0%	0.0%
Rhoslan Surgery (B120)	Central	36.8%	44.4%
Rysseldene Surgery (B122)	Central	61.8%	42.1%
Beechley (B257)	East	70.0%	100.0%
Hillcrest (B260)	East	68.1%	71.4%
Panton Surgery, Holywell (B182)	East	50.0%	33.3%
Pen y Maes (B244)	East	76.9%	83.3%
St Marks (B185)	East	84.2%	88.9%
The Laurels Surgery (B186)	East	53.3%	100.0%

4.3 Child at Risk Level 3 Programme of Learning

4.3.1 Safeguarding Children at Risk Level 3 is co-ordinated via 3-year training plan incorporating specific safeguarding topics identified from recommendations of child practice reviews and national reviews.

4.3.2 Topics include:

- Non-Accidental Injuries.
- Fabricated Induced Illness.
- Parental Neglect.
- Mental Health and Parenting.
- Lessons Learnt from Child Practice Reviews.
- Health Pre-Birth Assessment.
- Female Genital Mutilation.

4.4 Safeguarding Ambassadors

4.4.1 Engagement and support for Safeguarding Ambassadors continues, and further training dates for 2022-2023 are to be arranged. Corporate Safeguarding will continue to identify the clinical areas where there are few or no ambassadors to address the shortfalls in those areas. There have also been areas identified for ambassador training via desktop reviews.

4.4.2 Our total number of Safeguarding Ambassadors is currently one hundred forty-seven (147) and this is an increase of thirty-three (33) since during the Q3 and Q4. This is extremely encouraging and reflective of the awareness that safeguarding is the responsibility of all.

Table 14: **Safeguarding Ambassadors.**

Area	East	Central	West	Total
Total number of ambassadors	49	54	44	147

4.4.3 A Conference for Safeguarding Ambassadors was held during National Safeguarding Week in November 2021. A total of thirty-five (35) Ambassadors attended. This was positively evaluated by those who attended and will be run again during safeguarding week of the next reporting year.

Recommendation Child at Risk 2022-2023.

2 a) Additional Training sessions to double the number of Ambassadors in 2022-2023	Review end of Q2. Completion March 2023

4.5 Child Practice Reviews

4.5.1 There are currently five open child practice reviews across the Health Board.

Four (4) of these are within the East Area and one (1) within Central Area. There are no open Child Practice Reviews in West Area however a case will be submitted to the Child Practice Review Subgroup for consideration in May 2022. One (1) of the Child Practice Reviews in East is being progressed by Shropshire rather than North Wales Safeguarding Board.

4.5.2 In Central alongside the open case already identified there are two (2) further cases awaiting the initial Panel meetings which are scheduled for May 2022. There is also a further application been submitted for discussion at the next Child Practice Review sub-group.

4.6 Learning from Child Practice Reviews

4.6.1 Two (2) of the Child Practice Reviews One (1) from East Area and One (1) from Central Area, share the same theme of safe bathing not being followed. North Wales Safeguarding Children's board are lead agency for raising awareness of risk associated with bathing a baby. BCUHB will be directly involved in development and delivering of training.

4.6.2 Two (2) of the Child Practice Reviews in East area are in relation to young persons who took their life via hanging. Health chronologies have been completed and submitted and are awaiting review meetings where further analysis of combined chronologies can be achieved.

4.6.3 Key themes from recent Child Practice Reviews include disguised compliance and the lack of professional curiosity from all professionals, coping with crying, parental substance misuse and its impact on parenting capacity.

4.6.4 Learning from reviews is shared in Safeguarding Mandatory Training, Safeguarding Bulletins, Learning Events and Conferences, Safeguarding Forums and Children's Clinical Advisory Groups.

4.7 Trauma Risk Management (TRiM)

4.7.1 Trauma Risk Management is a peer-led process that seeks to identify and assess the psychological risk to individuals who have experienced trauma in the course of their work.

4.7.2 Early identification of staff exposed to trauma, aids to promote a healthy workforce, by supporting the welfare needs of staff, and contributes towards reducing staff absence.

4.7.3 There have been forty-one (41) Trauma Risk Management referrals received during 2021-2022, compared with twenty-nine (29) in 2020-2021.

Table 15: **Trauma Risk Management sessions by area.**

Area	Number
East	14
Central	13
West	14
Total	**41**

Table 16: **Trauma Risk Management sessions by clinical area.**

Clinical setting	Number of referrals
Community Services	8
Inpatient Services	19
MHLD/SMS	14

4.7.4 The themes for the referrals include assaults/verbal abuse of staff by patients, deaths of patients including children, medical emergencies and maternal deaths.

4.7.5 Of the forty-one (41) cases referred, seventeen (17) had no further action Rationale for the no further actions have been due to the referrals being received outside the timescales as indicated in the Trauma Risk Management Standard Operating Procedure. There is a risk of re-traumatising staff members if the Trauma Risk Management is not undertaken within timescales. There were also some referrals deemed inappropriate in terms of not meeting the threshold for Trauma Risk Management and staff who were not employed by BCUHB.

4.7.6 Feedback received both verbally and via the evaluation forms highlight that staff have found the process, helpful, supportive and beneficial.

4.7.7 There are currently twenty-two (22) Trauma Risk Management Practitioners across the Health Board including four (4) Trauma Risk Management managers. Some of the training was supported by Awyr Las funding.

4.7.8 From May 2020 to March 2022 there have been seventy (70) cases referred to Trauma Risk Management.

5. Multi – Agency Partnership

Rationale

The protection and safeguarding of vulnerable adults rely on multi-agency working and effective information sharing; working together to improve services and outcomes for all.

5.1 Procedural Response to Unexpected Deaths in Childhood (PRUDiC)

5.1.1 The North Wales Safeguarding Children's Board provides the governance arrangements around the Procedural Response to Unexpected Deaths in Childhood process within North Wales. All cases are monitored through the Regional Child Practice Review Subgroup.

5.1.2 The Procedural Response to Unexpected Deaths in Childhood Standard Operating Procedure has recently been reviewed and strengthens communication and process with out of area hospitals, for those children who unexpectedly die outside of North Wales.

Table 17: **Procedural Response to Unexpected Deaths in Childhood by year and area.**

Year	West	Central	East	Total
2018-19	2	4	8	14
2019-20	3	7	4	14
2020-21	2	4	3	9
2021-22	5	5	8	18

5.1.3 There have been 18 Procedural Response to Unexpected Deaths in Childhood across BCUHB in 2021-2022, this is double the number of cases when compared to last year. 61% of the children were aged two and under at the time of their death.

5.1.4 Themes include:

- Adverse Childhood Experiences experienced by the child themselves in six (6) cases. It is also noted in three (3) of the cases that parents had also potentially experienced Adverse Childhood Experiences in childhood.
- The children in four (4) of the cases had either previously or currently had involvement with the Local Authority under safeguarding processes.
- Trauma Risk Management offered to practitioners involved in all but one case.

5.2 Child Death Overview Panel

5.2.1 The Child Death Overview Panels continue to take place across North Wales in each of the three areas. They are well attended by senior management from all agencies responsible for safeguarding children. The purpose of the Child Death Overview Panel is to identify any matters relating to the death or deaths that are relevant to the welfare of children and any required actions.

5.2.2 During the reporting period we have had 18 child deaths.

Table 18: **Child deaths per quarter and area.**

Area	Q1	Q2	Q3	Q4	Total
East	0	2	3	2	7
Central	2	3	0	1	6
West	1	0	2	2	5

5.2.3 Safeguarding Specialists continue to attend the panel meetings and have a 100% attendance. This to ensure any safeguarding is considered, ensure learning is considered actions developed.

5.3 Multi- Agency Working with Partners

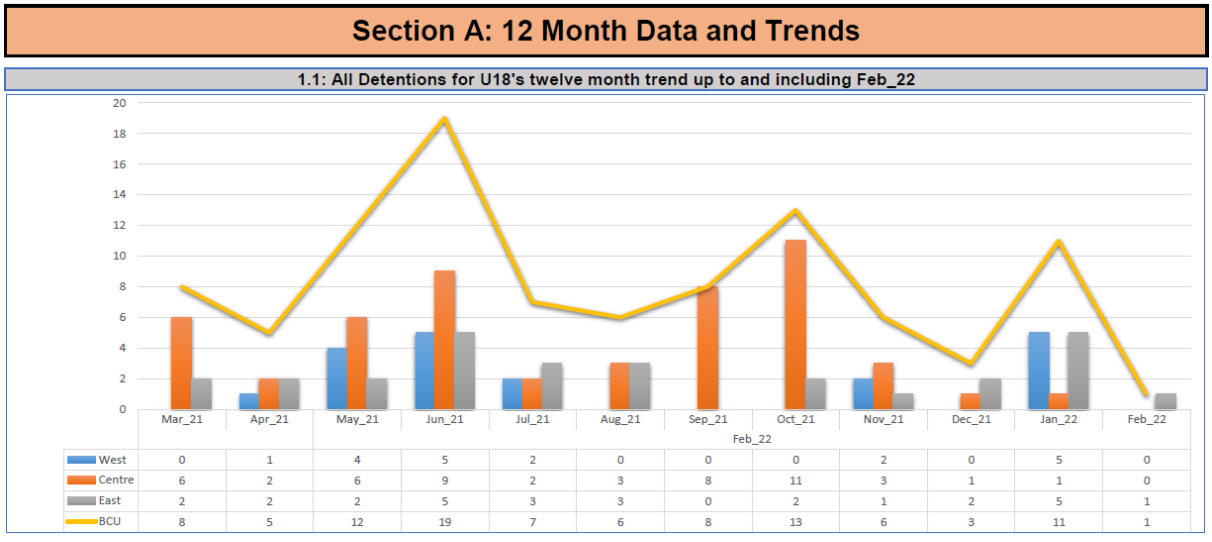
5.3.1 Multi-agency engagement is a statutory requirement of BCUHB. The Corporate Safeguarding Team have achieved 100% attendance at statutory Safeguarding Boards and Subgroups. The level of required engagement is high with the requirement of full participation and contribution to the Work Plan.

5.4 Section 135 & Section 136

Table 19: **Under 18s combined S135 & S136 Assessments.**

Area	Male under 18	Female under 18	**Total**
Central	2	16	**18**
East	1	22	**23**
West	4	8	**12**

Figure 6: All Detentions for under 18s twelve-month trend.



5.4.1 There was a significant increase in section 136 admissions in May and June 2021 with a further peak in September. There were a number of repeat presentations and significantly complex cases with these months. There is an additional developing pattern of increased admission in December.

For assurance, the head of Safeguarding for Children has presented this information to Child Adolescent Mental Health Service to develop a proactive response around this period moving forward.

5.4.2 From initial analysis of the Children and Young People needing admissions under 136. There is developing pattern regarding females being admitted. For assurance within Q1 2022-2023 the head of Safeguarding for Children will create an action to explore this pattern to understand the need and what proactive safeguards are required to address the identified concern.

5.4.3 The head of Safeguarding is member of BCUHB, Child Adolescent Mental Health Service strategic improvement and development steering group, as well as the developing Rapid Response Crisis model to reduce the potential 136 admission. This ensures there is strategic oversight and involvement from the corporate safeguarding team remains a focus across any strategic and operational planning.

5.5 Liberty Protection Safeguards (LPS) 16/17-year-olds

5.5.1 Deprivation of Liberty Safeguards authorisations only authorise the actual deprivation of liberty, whereas LPS authorisations authorise the arrangements for care that give rise to the deprivation of liberty. This is an important distinction since the new process focuses more on the support and care of the child.

5.5.2 The Head of Safeguarding Children attends the National Liberty Protection Safeguards 16/17-year-olds meetings. The key areas discussed include promoting an understanding of roles and responsibilities, communications, information and supporting materials, training and data monitoring/reporting and mapping of the Articles of the United Nations Convention on the Rights of the Child particularly relevant to Liberty Protection Safeguards.

6. Learning Culture

6.1 Child Adolescent Mental Health Service cases & activity

6.1.1 Child Adolescent Mental Health Service cases continue to be a significant cause for concern across the region. Many young people presenting at Emergency Departments and being supported for assessment under the Child Adolescent Mental Health Service Crisis Pathway or more formally under section 136 of the Mental Health Act (1983)

6.1.2 Concern over appropriate provision of inpatient facility out of hours in crisis situations as this are not always possible within Tier 4 service provision at North Wales Adolescent Service. There is a change in the model of care, focus now is assess to admit rather than admit to assess. This remains in its infancy and Corporate Safeguarding have supported the staff implementing this model in relation to appropriate reporting of Child at Risk concerns.

6.1.3 Corporate Safeguarding have engaged in case reviews to identify learning and promote Lessons Learnt. As a result of this engagement Corporate Safeguarding can actively support action plans to ensure all safeguards are considered.

6.1.4 Where there are safeguarding concerns and complex legal considerations, Corporate Safeguarding are fully engaged in case meetings.

7. Violence Against Women Domestic Abuse Sexual Violence (VAWDASV)

7.1 Violence Against Women Domestic Abuse Sexual Violence Training

Table 20: **BCUHB overall Violence Against Women Domestic Abuse Sexual Violence Training Compliance.**

Safeguarding Module	March 2021	March 2022	Trajectory
VAWDASV	75%	65.5%	↓

7.1.1 The overall BCUHB compliance has decreased in 2021-2022.

7.1.2 Causative factors include – staff sickness, self-isolation due to COVID-19 infection, staff redeployment to support the COVID-19 vaccination programme and a high number of non-attendees.

7.1.3 Corporate Safeguarding have worked with the mandatory training department in increasing the capped numbers of attendees at the virtual training sessions. This will increase the capacity of attendees by reaching a greater audience.

7.1.4 All divisions and service areas are below the 85% target compliance. This issue has been raised in safeguarding forums and relevant meetings.

7.1.5 The highest performing divisions are Area Teams East and West, Mental Health and Learning Disability and Womens.

7.1.6 The lowest performing divisions are Estates and Facilities and Corporate Services.

7.1.7 Each Division is required to review the compliance data and provide assurance in the Safeguarding Forums of improvements.

Table 21: **Emergency Department Violence Against Women Domestic Abuse Sexual Violence Training Compliance.**

ED March-22 Compliance	Staff	2020-2021	2021-2022	Trend	Update Position July22
YG Medical	52	40.0%	46.2%	↑	53.7%
YG Nursing	69	87.0%	73.9%	↓	71.6%
YGC Medical	39	45.0%	38.5%	↓	38.2%
YGC Nursing	96	79.0%	63.5%	↓	58.9%
WMH Medical	36	38.0%	47.2%	↑	50%
WMH Nursing	108	85.0%	71.3%	↓	72.4%

7.1.8 There has been a decrease in compliance across the Emergency Department in 2021-2022 except in Ysbyty Gwynedd Medical and Wrexham Maelor Hospital Medical where there has been an increase.

7.1.9 Ysbyty Glan Clwyd Emergency Department is the lowest performer for both Medical and Nursing.

However, all the subject areas are below BCUHB key performance indicator of 85%. This has been escalated within the Safeguarding and Governance Performance Group and all service areas are expected to give a trajectory within future reports.

7.2 Multi Agency Risk Assessment Conference (MARAC)

Table 22: **Multi Agency Risk Assessment Conference Referrals 2018-2022.**

Year	West	Central	East	Total
2018-19	46	57	68	171
2019-20	66	53	61	180
2020-21	46	68	63	177
2021-22	54	83	64	201

7.2.1 There have been 201 Multi Agency Risk Assessment Conference referrals from health in 2021-22. All three areas have seen an increase, particularly Central, where numbers have risen by 22%.

7.2.3 It is widely recognised that disclosures of domestic abuse have increased since the COVID-19 pandemic and this could account for the increase that has been seen within health.

7.2.4 When analysing the age and gender of the victims, 48% of the referrals were in respect of victims aged between 25 and 39 years of age. 95% of these referrals have been in relation to female victims.

7.2.5 Upon reviewing the relationship of the perpetrator to the victim, 41% (n=82) record the perpetrator as current partner/husband/wife. 40% (n=80) of the referrals record the relationship of the perpetrator as ex-partner.

7.2.6 65% (n=131) of the victims have children and 30% (n=60) were pregnant at the time of the referral. The Domestic Abuse Act 2021 will see children who live in a home where domestic abuse takes place recognised as victims in their own right rather than witnesses for the first time. The Act will recognise a child who sees or hears, or experiences the effects of, domestic abuse and is related to the person being abused or the perpetrator is also to be regarded as a victim of domestic abuse.

7.2.7 When considering the designation of referrer's, Health Visitors submitted the highest number of Multi Agency Risk Assessment Conference referrals with 24% (n=48), followed by midwives 19% (n=39) and the emergency department 17% (n=35). This is a similar picture to 2020-2021.

7.3 Multi Agency Risk Assessment Conference Meetings

7.3.1 Multi Agency Risk Assessment Conference meetings continue to occur virtually in this reporting period. Across all regions there continues to be weekly Multi Agency Risk Assessment Conference meetings in each local authority along with a monthly Multi Agency Risk Assessment Conference meeting that incorporates a wider range of agencies.

7.3.2 The Head of Safeguarding Children (accountable for Violence Against Women Domestic Abuse Sexual Violence) has scoped the operational impact of the increase in activity. The Corporate Safeguarding Team hold the accountability for researching and providing accurate information at the meetings.

7.3.4 Operational Implications for both BCUHB and North Wales Police included:

- Case list being received from North Wales Police is usually not timely and is creating resource issues for the team.
- Quality of Information might not be of the highest standard due to a limited time being given to the research process.
- Health staff need to focus on the information shared in terms of relevancy
- Some agencies (not health) are not attending the weekly meetings so cases are delayed to the monthly meetings.
- Actions are not updated prior to the meetings which creates timing issues during the meetings.

- Health visitor and school nurse cover varies and is not always the person listed on the system which can increase time pressure in trying to identify the correct person to gain the information from.
- The lists of cases to be discussed are long which is positive in relation to a timely and proportionate response being gained, However, there is a risk around the quality of the information that can be reasonably gained from a health perspective given the number of cases and the time frame to provide the information.

7.3.5 A further scoping exercise was undertaken at the end of Q3 to map out the BCUHB internal processes in relation to the Multi Agency Risk Assessment Conference, to achieve some parity across the region. Issues around timing of the release of the case lists and receipt of actions and minutes were identified. Work is ongoing with the Detective Inspector responsible for Multi Agency Risk Assessment Conference from North Wales Police to address these, and this is being reviewed within the Regional Multi Agency Risk Assessment Conference Steering Group.

7.4 Work Place Safety Groups

7.4.1 The Work Place Safety Groups are in place across the three (3) Areas within the Health Board to offer support to the managers who are supporting staff, either victims or perpetrators of domestic abuse. Data has been collected during this reporting period.

Table 23: **Number of staff supported in Workplace Safety Groups 2021-2022.**

	East	Central	West	**Total**
2021-2022	6	6	3	**15**

7.4.2 Most of the referrals were received in Q3 and Q4. The low numbers could be attributed to lack of staff awareness, which could be affected by the low numbers of staff who have completed the Violence Against Women Domestic Abuse Sexual Violence training. These low numbers, could potentially reflect some staff who are lacking support when involved in domestic abuse incidents, subsequently increasing the risks.

7.4.3 The profile and purpose of this meeting continues to be raised in the Areas and Mental Health and Learning Disability Safeguarding Forums and Quality and Safety Groups across the Health Board and in Q3 and Q4 there was an increase in the number of referrals submitted.

7.4.4 With the appointment of the health Independent Domestic Violence Advisor's in west and central, there might also be an increase in referrals in the next reporting period once those roles are embedded within practice.

7.5 Domestic Homicide Reviews (DHR)

Table 24: **Number of Domestic Homicide Reviews from 2019-2022.**

Year	Number of live DHRs	Number signed off	Number Ongoing
2019-2020	3	0	3
2020-2021	4	2	4
2021-2022	4	3 by BCUHB but awaiting Home Office sign off	4

7.5.1 A Wrexham Domestic Homicide Review has been commissioned but has yet to commence due to criminal proceedings.

7.5.2 Manchester Community Safety Partnership have commissioned a Domestic Homicide Review involving a victim who resided between Wrexham and Manchester. The victim died by taking an overdose of medication.

7.5.3 Gwynedd Community Safety Partnership have commissioned 2 Domestic Homicide Reviews that are ongoing. One case involves an adult suicide and one is the death of a father, allegedly perpetrated by his son.

7.5.4 There are currently no Domestic Homicide Reviews open within the Central Area which was consistent in 2020-2021.

7.5.5 Identified learning includes;

- Improving information recorded on electronic systems.
- Improved sharing of legislative information with GP practices.
- Increased availability of Violence Against Women, Domestic Abuse and Sexual Violence training for GPs.
- Improved communication pathways between Mental Health and Learning Disability and GPs.
- Quarterly audits of clinical records in relation to Domestic Abuse targets.
- Promotion of safeguarding supervision within high-risk adult service areas.
- Review and Relaunch of Supporting Children, Supporting Parents: A North Wales Multi-Agency Protocol. Parents with severe mental health problems and/or substance misuse: A framework for safeguarding children.

7.5.6 Main themes and trends identified: Mental health and substance misuse featured in the reviews, adult suicide's (victims linked to domestic abuse) one couple were over 70 years of age, lack of compliance with Routine Enquiry Domestic Abuse, perpetrator male and victim female and relationship of the perpetrator to victim was husband/partner and wife/partner.

7.5.7 Risks identified: the omission in Routine Enquiry Domestic Abuse in high-risk areas removes the opportunity for victims, to safely disclose domestic abuse and increases the risk of them experiencing escalating domestic abuse, a lack of referral to specialist services and in some cases a homicide.

7.6 Agencies Domestic Abuse Perpetrator Tasking (ADAPT)

7.6.1 Chaired by North Wales Police, Agencies Domestic Abuse Perpetrator Tasking is a multi-agency approach to domestic abuse perpetrators with the aims to reduce the re-offending of domestic abuse perpetrators, ensure safeguarding adults and children at risk of domestic abuse and to break the cycle of abuse of the perpetrator by changing or disrupting offender behaviour.

7.6.2 Initially piloted in the central area in 2019, North Wales Police now chair a multi-agency monthly panel across each of the 6 local authorities to discuss a cohort of domestic abuse perpetrators.

7.6.3 This was implemented for East and West in Q4. Health representatives include the substance misuse service, mental health division and corporate safeguarding.

7.6.4 Corporate Safeguarding continue to engage in Agencies Domestic Abuse Perpetrator Tasking and have achieved a 100% attendance record. Whilst the Agencies Domestic Abuse Perpetrator Tasking is a perpetrator focused meeting, the risk management plans are designed to benefit adult victims and any children associated with the cases.

7.7 Identification and Referral to Improve Safety (IRIS)

7.7.1 The Identification and Referral to Improve Safety programme involves training and support for GP's to be able to identify patients affected by domestic violence and abuse and refer them to specialist services.

7.7.2 Identification and Referral to Improve Safety provides a unique opportunity for primary care clinicians and their patients to talk about the issue. Victims of domestic violence and abuse will often visit their GP with a variety of symptoms that are not obviously connected to violence, such as anxiety, depression, stress and substance use.

7.7.3 As most GP's have had little or no training in how to identify patients affected by domestic violence, they often fail to recognise patients experiencing abuse and are uncertain about future care after disclosure.

7.7.4 £20k has been received from the Ministry of Justice to support this pilot project which will be piloted in the central area, specifically in 8 GP practices in south Denbighshire.

7.7.5 Corporate Safeguarding have been involved in the Steering Group and the first cohort of training for GP's is being delivered in April 2022.

Priority Action 23 (2022-2023).

Continued engagement in the Identification and Referral to Improve Safety Project in 2022-2023	March 2023

7.8 Pilot project for the Independent Domestic Violence Advisor role in BCUHB.

7.8.1 Funding has been received from the Ministry of Justice to pilot two hospital based Independent Domestic Violence Advisor, one in Ysbyty Glan Clwyd and one in Ysbyty Gwynedd. These posts will be managed by the Domestic Abuse Safety Unit and Gorwel but will sit within BCUHB Corporate Safeguarding Team.

7.8.2 The Hospital based Independent Domestic Violence Advisor will provide immediate, high quality, trauma informed support and advice to victims of domestic abuse accessing Ysbyty Glan Clwyd and link survivors to longer term community-based support. The hospital based Independent Domestic Violence Advisor will work closely alongside hospital staff, providing expert advice and raising awareness to support the disclosure of domestic abuse.

7.8.3 The role involves empowering survivors to increase their options, make positive choices/decisions, increase their confidence, safety and recovery.

7.8.4 The central Independent Domestic Violence Advisor commenced in post in February 2022 and her presence is growing from strength to strength. The West Independent Domestic Violence Advisor is expected to commence in post in May 2022. The pilot will be evaluated.

7.8.5 The Regional Violence Against Women, Domestic Abuse and Sexual Violence Commissioning Group has been approach regarding potential funding for an Independent Domestic Violence Advisor based in Wrexham Maelor. Domestic Abuse Safety Unit are keen to pursue this.

Priority Action 24 (2022-2023).

Continued engagement in the Independent Domestic Violence Advisor Project in 2022-2023	March 2023

7.9 Domestic Abuse Act 2021

7.9.1 On the 29th of April 2021, the Domestic Abuse Act 2021 was granted Royal Assent and became law and will be fully implemented by May 2022. This Act supports and strengthens the domestic abuse element of the Violence Against Women, Domestic Abuse and Sexual Violence Act 2015, especially within the police and criminal justice system.

7.9.2 The Act sets out the first definition in law of what constitutes domestic abuse and for the first time, a child who sees or hears, or experiences the effects of domestic abuse is now classed as a victim of domestic abuse in their own right. key criminal justice changes include a new offence of non-fatal strangulation, extending the controlling or coercive behaviour offence and criminalising the threat to disclose intimate images with the intention to cause distress.

7.9.3 The NHS G2 Violence Against Women Domestic Abuse Sexual Violence training package has been updated to include this legislation and BCUHB have engaged in the consultation process of the Draft Statutory Guidance Framework.

7.10 Violence Against Women Domestic Abuse Sexual Violence National Strategy 2021-2026

BCUHB have contributed and engaged in the consultation process which ended in February 2022. Corporate Safeguarding co-ordinated the BCUHB response.

7.11 National Violence Against Women, Domestic Abuse and Sexual Violence Steering groups

7.11.1 North Wales Vulnerability and Exploitation Board

The Director of Safeguarding and Public Protection represents BCUHB at this Board. BCUHB have developed a Delivery Plan to feed into the Regional Strategy and Development Plan to ensure a cohesive framework upon which to drive forward the work of all organisations involved, in the delivery of the Violence Against Women Domestic Abuse Sexual Violence and Modern Slavery agendas. This will enable the Board to measure successes against the Delivery Plan and support all agencies to meet their legislative duties.

Corporate Safeguarding have been 100% compliant in their completion of the quarterly Delivery Plans ensuring full engagement.

7.11.2 All Wales Minimum Standards for Routine Enquiry into Domestic Abuse, Pregnancy and Early Years

A recommendation from the audit of the All-Wales Minimum Standards 2009 was to conduct a review. The Task and Finish Group was chaired by Welsh Government and the Working Group was chaired by the Head of Safeguarding Children BCUHB. The revised standards were ratified at the Chief Nursing Officer meeting in February 2022 and an internal BCUHB implementation plan has been devised.

Priority Action 25 (2022-2023).

Implement the All-Wales Minimum Standards into Domestic Abuse across all relevant areas in BCUHB.	June 2022

7.11.3 National Violence Against Women Domestic Abuse Sexual Violence Steering Group

The National Violence Against Women Domestic Abuse Sexual Violence Steering Group is a Subgroup of the All Wales Safeguarding Network. The Group have continued to meet quarterly during 2021-2022 with 100% engagement from BCUHB. The focus of the group has been around Routine Enquiry Domestic Abuse and the revision of the Work Plan.

7.11.4 Regional Violence Against Women Domestic Abuse Sexual Violence Commissioning and Training Subgroups

The Commissioning and Training Subgroups are well attended by BCUHB with full engagement and participation.

7.11.5 Regional Multi Agency Risk Assessment Conference Steering Group

This Group has recently been developed to monitor and oversee the activities of the Multi Agency Risk Assessment Conference. Terms of Reference have been developed with the Group reporting to the North Wales Vulnerability and Exploitation Board. BCUHB provides full engagement and participation. Work is ongoing to ensure there is parity across the region in relation to Multi Agency Risk Assessment Conference processes, and BCUHB are working closely with North Wales Police to address this.

7.11.6 Regional Sexual Violence Steering Group

This Group has been identified as a gap in service co-ordination and delivery and has been developed in Q3 2021-2022 with the Head of Safeguarding Children (Lead for Violence Against Women Domestic Abuse Sexual Violence) attending. The purpose of the group is to promote learning/development in the area of sexual violence and to share national updates and local impact. A multi-agency approach provides strategic oversight and support for the delivery of this agenda.

7.11.7 Regional Identification and Referral to Improve Safety Steering Group

The Steering Group provides a co-ordinated approach and strategic oversight to the Identification and Referral to Improve Safety Project. Corporate Safeguarding are fully engaged in this group.

7.11.8 Sexual Assault Referral Centre

Amethyst Sexual Assault Referral Centre has continued to maintain a high-quality service to meet the needs of the high number of complex individuals accessing the Service throughout the year 2021-2022 and over the period of the COVID-19 pandemic.

Forensic medical examinations associated with acute cases of sexual violence increased to 156 compared to 98 in 2020-2021.

Referrals into the service overall, including non-recent cases, recorded at 491 which is an 8% increase in pre COVID-19 activity.

The Ministry of Justice have supported the Independent Sexual Violence Advisor service with additional continued funding for 2022-2025 for 5 Independent Sexual Violence Advisors, taking the overall service to 10 Independent Sexual Violence Advisors. This will provide the additional resources needed to meet the increase in demand.

7.11.9 **Lime Culture Independent Sexual Violence Advisor / Children and Young People Sexual Violence Advisers service accreditation**

This accreditation is part of a national quality standard for Independent Sexual Violence Advisor and Children and Young People Sexual Violence Advisers services to ensure that every victim/survivor should be able to access a high quality, well managed Independent Sexual Violence Advisor/ Children and Young People Sexual Violence Advisers service across the UK, regardless of their age, gender, race, sexuality or beliefs. It also reflects and supports the professional status and quality of the service provided both to other professional organisations. The accreditation process was initiated in Q3 by one Independent Sexual Violence Advisor and one Children and Young People Sexual Violence Advisers and is anticipated to be completed in Q1 2022. The direct benefits of undertaking the accreditation work are that it will align the services working practices, including administrative process.

7.11.10 **ISO Standard for Sexual Assault Referral Centres / Forensic Science Regulator Guidance**

The Forensic Science Regulator has published supporting Guidance and Codes of Practice and Conduct to support the attainment of International Standards for Anticontamination of Sexual Assault Referral Centres and Assessment, Collection and Recording of Forensic Science related evidence. North Wales Police have the legal entity for the review and are working in partnership with BCUHB. Corporate Safeguarding are accountable for this review on behalf of BCUHB. North Wales Police have appointed a Project Manager and Strategic Lead and a Service Delivery Group has been developed. Completion of the ISO Standards is required by October 2023.

Priority Action 26 (2022-2023).

Continue engagement and support with the ISO Standards.	March 2023

7.11.11 **Awards**

The Sexual Assault Referral Centre manager and three Independent Sexual Violence Advisors have been nominated for and awarded a Chief Constable Commendation in recognition for the exceptional work, professional and expertise they have provided to Operation Greenest, the North Wales Police Investigation into sexual assaults of males. The emotional and practical support provided to the victims during the investigation was invaluable as was the advice and support they gave the investigation team. It is also recognised that the team went above and beyond what was required from them. The victims voiced their praise for the support they received at what was a very difficult time for them.

7.11.12 **Female Genital Mutilation**

Table 25: **The data for reported Female Genital Mutilation cases 2016-2022.**

Year	Cases
2016-17	6
2017-18	6
2018-19	5
2019-20	5
2020-21	2
2021-22	5

All the cases reported during 2021-2022 were pertaining to adult survivors of Female Genital Mutilation who had female children. None of the children referred had Female Genital Mutilation. Four of the reports were from maternity services, all in the East area, and one was from health visiting in the West.

This has been cross checked against the datix system to ensure that no cases have been missed.

Female Genital Mutilation continues to be part of the Level 3 Safeguarding Children Programme and the package was updated during the reporting period. The Female Genital Mutilation action plan has been reviewed and updated since the Safeguarding Midwifery Lead has been in post. Training for Sexual Health services on Female Genital Mutilation was delivered during safeguarding week in November 2021 and this was positively evaluated by those who attended.

Nationally, there has been some work undertaken By Public Health Wales, with the support of BCUHB Corporate Safeguarding, to update the All-Wales Female Genital Mutilation Clinical Pathway. The main challenge to the existing pathway is related to the requirement to submit Child At Risk reports for female babies/children of women survivors of Female Genital Mutilation, where there is no risk identified, which is the current practice. There are risk assessment tools from the Department of Health that can be used to assess risk and inform the need to submit a Child At Risk report for this cohort of survivors. This would support a trauma informed approach.

The mandatory reporting duty for under 18's is in Legislation and will not therefore be affected by this change.

Once the updated pathway has been finalised, the BCUHB guideline will be updated to reflect any changes and amendments, and will then be launched, supported by the updates to training packages and additional training sessions if needed.

Priority Action 27 (2022-2023).

Implementation of the updated All-Wales Female Genital Mutilation Clinical Pathway across BCUHB.	September 2022

8. Safeguarding Midwifery

8.1 Introduction

8.1.1 This report (April 2021 – March 2022) provides an overview of progress made in relation to the activities and priority actions highlighted in the Corporate Safeguarding Annual Report April 2020 - March 2021.

8.1.2 Data contained in this report, evidence that 15.5% of Child At Risk reports are submitted by midwives, demonstrating an increasing amount of activity in this area. Findings from Child Practice Reviews inform us that almost half that are undertaken are related to a baby under a year of age and that quality pre-birth risk assessments is key to identifying indicators of harm and preventing future harm.

8.2 Routine Enquiry into Domestic Abuse

8.2.1 The table below provides us with the compliances for Routine Enquiry from the beginning of 2020-2021 by quarter to date for comparison and trend.

Table 26: **Routine Enquiry Compliance 2021-2022.**

BCUHB	Audited Notes	Asked Once	Asked Twice	Not Asked At All	Mitigation – Accompanied	Mitigation – No Reason Given
Q1 2020-21	135	80%	67%	20%	12%	8%
Q2 2020-21	135	91%	73%	9%	1%	7%
Q3 2020-21	135	82%	73%	18%	1%	17%
Q4 2020-21	135	89%	80%	11%	1%	10%
Q1 2021-22	135	92%	84%	8%	0%	8%
Q2 2021-22	135	92%	81%	8%	1%	7%
Q3 2021-22	135	92%	80%	8%	1%	7%
Q4 2021-22	135	92%	78%	8%	1%	7%

8.2.2 Across BCUHB, the 2021-22 audit has established that compliance in relation to the routine enquiry questions has improved in comparison to the previous year. Compliance for 2019-20 was 86% and therefore, there has been an improvement over all of six percentage.

8.2.3 92% of women had been asked the routine enquiry questions at least once at their antenatal appointment in BCUHB. This is consistent with what has been seen in each quarter of 2021-22.

8.2.4 78% of women were asked the routine enquiry questions twice or more. This is an improvement in compliance when compared to Q3.

8% of the women were not asked at all. This is consistent with what has been seen in each quarter of 2021-22.

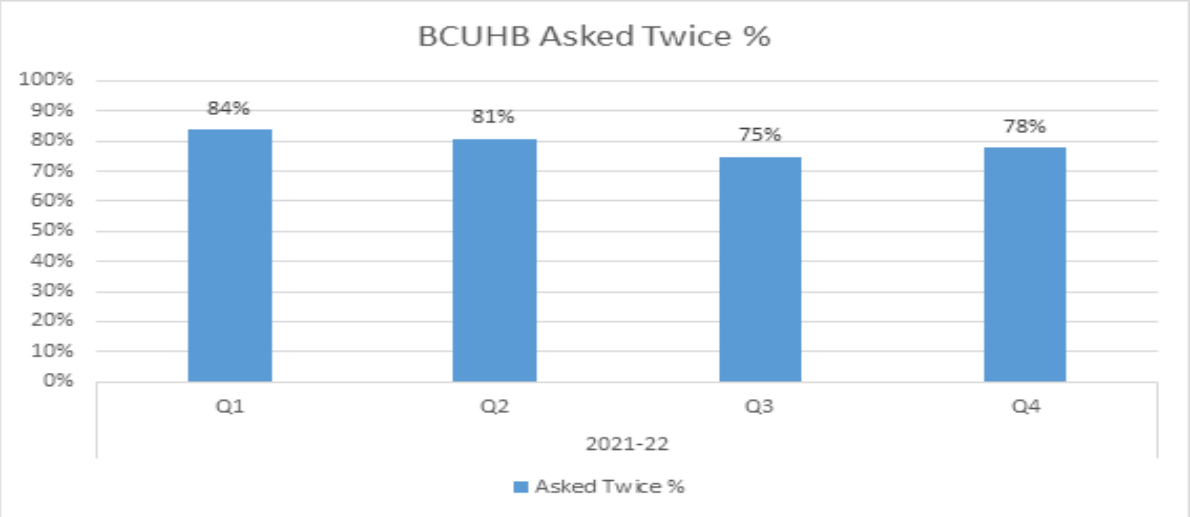
No reason was given as to why the majority of women were not asked. However, it is documented that 1% of the women were not asked as they were accompanied during their appointment.

8.2.5 Targeted work has been, and continues to be undertaken, alongside the Community Midwifery matron, and the audit will continue into 2022-2023 to monitor sustained compliance and the recording of mitigation for when women are not asked.

8.2.6 The overall improvements could be partially attributed to the restrictions in visiting during the COVID-19 pandemic. However, these restrictions were eased in September 2021 to allow a birth partner to attend antenatal appointments in the community. Overall, for women being asked twice or more, there has been a reduction by 3%, when comparing Q2 to Q4.

8.2.7 The figure 7 below, highlights that the overall percentage of women being asked the routine enquiry questions twice or more was at its lowest during Q3 of 2021-2022. This coincides with the change in circumstance allowing partners to accompany women at their antenatal appointments. The compliance percentage increased in Q4 however, has not reached the levels of both Q1 and Q2.

Figure 7: Women who were asked REDA twice 2021-22.



8.2.8 Compliance will continue to be closely monitored to ensure that this does not have a detrimental effect on routine enquiry.

8.2.9 Compliance is also being reviewed as part of the Stillbirth Reduction action plan within the women's division, following on from the thematic review in 2019.

Priority Action 28 (2022-2023).

Women's Division to lead, with support/engagement from the Safeguarding Midwives, on an audit of compliance with Routine Enquiry Domestic Abuse.	March 2023

8.3 Coping with Crying

8.3.1 Following on from the Child Practice Review for Child A in Flintshire, it was recommended that BCUHB review the Coping with Crying guideline and also audit compliance with the guideline. This was also a priority action from the 2020-2021Corporate Safeguarding Team Annual Report.

8.3.2 Child A was a 10-month-old baby who sustained significant head injury consistent with a Non-Accidental Injury. Child A survived, however has significant impairment as a result of the trauma suffered.

8.3.3 Based on the guideline, the audit has included midwifery, neonates and health visiting.

8.3.4 The audit commenced in October 2021 for a period of 6 months with the outcome and report to be made available in Q1 of 2022-2023.

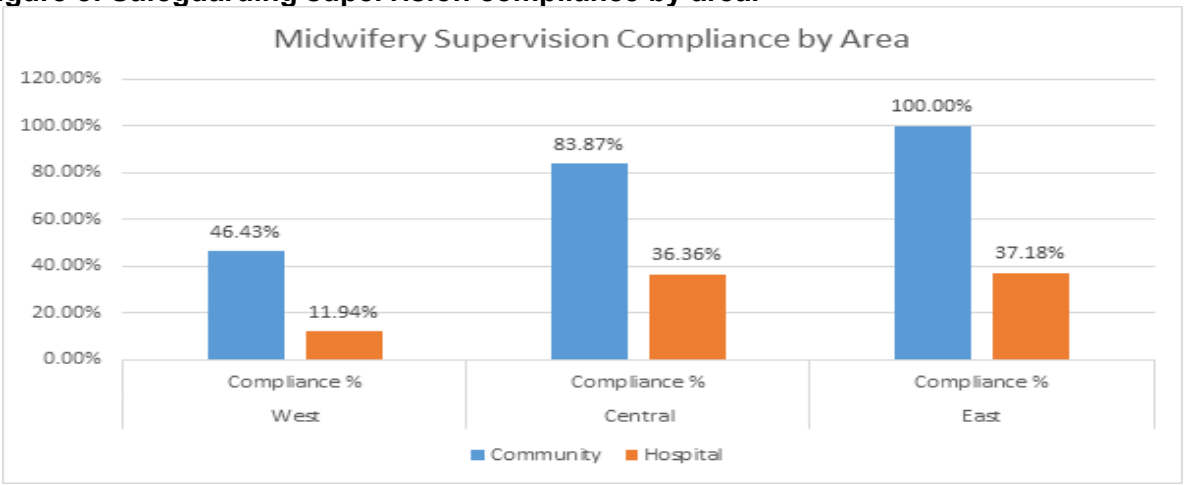
8.4 Safeguarding Midwifery Supervision

8.4.1 Based on the overarching BCUHB Safeguarding Supervision Guideline, safeguarding supervision is provided for community midwives on a one-to-one basis, twice a year. Group supervision is currently provided for all midwives as part of overall safeguarding children level 3 compliance. Midwives who work in the acute areas are not expected to participate in safeguarding supervision.

8.4.2 A priority action from the Corporate Safeguarding Team Annual Report (2020-2021) was to review and update the safeguarding supervision database for midwifery, to ensure that data was being captured accurately, as compliance with safeguarding supervision has been poor. With the support of the Information Officer from the Corporate Safeguarding Team this was updated, and supervision compliance has been seen to be increasing since its inception.

8.4.3 The figure 8 below demonstrates compliance across all areas at the end of Q4.

Figure 8: Safeguarding supervision compliance by area.



8.4.4 The compliance for both community midwives and acute midwives in the West, is lower than the other areas. There is a plan in place to address this with the Womens division in the West. Group supervision sessions have been streamlined and are now being held monthly for all areas rather than one per area, freeing up midwifery specialist time to focus on 1-1 supervision. This will also mean that staff absence should not significantly impact negatively on compliance.

Overall compliance was 35% for all community midwives in the region and 3% for acute midwives at the beginning of Q1 2021-2022.

8.4.5 The table 28 below demonstrates a significant improvement in the overall compliance across the region at the end of Q4.

Table 27: **Overall safeguarding supervision compliance across Women's.**

Compliance	BCUHB	
	Number of staff Compliant	Overall %
Community	69	75.8%
Hospital	64	28.8%
Overall	133	42.5%

8.4.6 The Safeguarding Specialist Midwives have continued to have a significant presence in the acute areas and also out in the community midwifery settings, to provide face to face support. This has been greatly valued by the midwifery staff.

8.4.7 Despite not requiring safeguarding supervision as per the policy, midwives in the acute areas (for example, labour ward, postnatal ward) access responsive supervision when needed.

8.4.8 Providing regular safeguarding supervision to the acute based midwives could strengthen practice and reduce the need for responsive ad-hoc supervision. Based on this, a review of the current model is needed and is planned for 2022-2023 as part of the Safeguarding Midwifery Leads strategic objectives.

Priority Action 29 (2022-2023).

Midwifery Safeguarding Lead to undertake a review of the current model of the delivery of safeguarding supervision to midwives	September 2022

8.5 Midwifery Safeguarding Children Level 3 Training.

8.5.1 Based on the Intercollegiate Document, Midwives require a minimum of 12 hours of safeguarding level 3 training over 3 years. This is achieved by 4 hours of training per year built into the midwifery mandatory training programme and delivered by the Safeguarding Specialist Midwives.

Table 28: **Midwifery training compliance 2021-22.**

Safeguarding Module	2020	2021	Trajectory
Safeguarding Children L3	92%	97%	↑

8.5.2 The overall BCUHB compliance has increased since 2020.

8.5.3 Midwifery compliance at the end of Q3 2021-2022, (training is reported based on calendar year rather than financial) was reported by the Womens Division as 97%. Womens maintain their own data in relation to Level 3 safeguarding training as this is provided as part of Midwifery mandatory training. The safeguarding specialist midwives provide 4 hours of training within this.

8.5.4 For Q1, 2 and 3, there were 3 sessions per month, one in East, Central and West. This continues to be delivered via MS teams.

8.5.5 From Q4, Womens changed their mandatory training to have two sessions per month, across the three areas, rather than one per area. This has been an efficient change to training delivery for the specialist midwives.

8.5.6 A bespoke training package was developed for the newly qualified midwives that was delivered in August 2021 and was very well evaluated. This will now be delivered the new cohort of newly qualified midwives every August going forward.

8.5.7 For 2022, the new training programme for midwives includes parents with learning disabilities (as a recommendation from a Child Practice Review) and a generic Level 3 package, to include the learning outcomes as outlines in the Intercollegiate Document. Both are 2-hour sessions.

8.5.8 The below table shows the overall safeguarding specific modules training compliance in Midwifery.

Table 29: **Overall Safeguarding Specific Modules Compliance 2021-2022.**

Compliance	Dec-21	Mar-22	Trend
MCA – Level 1	89.2%	85.5%	↓
MCA – Level 2	89%	84.2%	↓
Adults – Level 1	89.7%	89%	↓
Adults – Level 2	88.7%	88.4%	↓
Children – Level 1	92.7%	92.6%	↓
Children – Level 2	93.5%	92.3%	↓
VAWDASV	85.9%	78%	↓

8.5.9 Midwifery has seen a reduction in compliance in all seven safeguarding modules during Q4. However, compliance remains above the BCUHB target of 85% in five of the seven modules. This will be addressed via the Womens Mandatory Training Group.

It is worth noting that there were significant challenges during the winter months in relation to COVID-19 pressures with both staffing and activity.

8.6 North Wales Pre-Birth Protocol.

8.6.1 The Safeguarding Midwifery Lead worked closely with the North Wales Safeguarding Children's Board to review and update the Pre-birth guidelines ahead of its re-launch in October 2021.

8.6.2 The Safeguarding Midwifery Lead and Specialist Safeguarding Midwives were involved in the delivery of this training and the final draft of the Pre-Birth protocol is awaiting sign off by the North Wales Safeguarding Children's Board. Once signed off, the protocol will be launched within BCUHB.

8.7 Information Sharing with Shrewsbury and Telford Hospital NHS Trust and the Countess of Chester.

8.7.1 Approximately 250 babies per year are born in the Wrexham Maelor where the mothers reside in Shropshire. Antenatal and postnatal care is provided by Shrewsbury and Telford Hospital midwives however the women come to Wrexham to birth.

8.7.2 For the Countess of Chester Hospital, approximately 350 women choose to birth there, but reside within BCUHB catchment, usually from Flintshire.

8.7.3 As such, there is need ensure that the information sharing pathways are robust so that women with additional vulnerabilities and safeguarding issues are brought to the attention of BCUHB in a timely way.

8.7.4 The Safeguarding Specialist Midwife in East, along with the maternity ward manager from Wrexham, will attend the Shrewsbury and Telford Hospital safeguarding multidisciplinary meetings where Wrexham specific cases are discussed to ensure that information is shared.

8.7.5 The pathway for Shrewsbury and Telford Hospital is operational and has been signed off within the Womens division and Corporate Safeguarding.

8.7.6 Initial discussions with Countess of Chester Hospital commenced during Q4 and the information sharing pathway is currently being devised and should be signed off during Q1 2022-2023.

8.7.7 We will also establish a monthly meeting, to replicate the Shrewsbury and Telford Hospital model, to ensure open lines of communication about women booked there but residing in the BCUHB area.

8.7.8 Bi-monthly meetings between the Shrewsbury and Telford Hospital and BCUHB, and Countess of Chester Hospital and BCUHB safeguarding teams and ward management continue in the interim to address any issues that might arise.

Priority Action 30 (2022-2023).

Information Sharing Pathway for BCUHB and The Countess of Chester Hospital to be devised and agreed.	December 2022

8.8 Child at Risk Reports

8.8.1 The table 30 below outlines the Child at Risk reports submitted by midwives during 2021-2022.

Table 30: **Child at Risk reports submitted by midwives.**

2021-22	West	Central	East	Out of Area	Total
Q1	28	53	39	-	**120**
Q2	25	67	53	1	**146**
Q3	25	76	38	-	**139**
Q4	26	84	49	2	**161**
Total	**104**	**280**	**179**	**3**	**566**

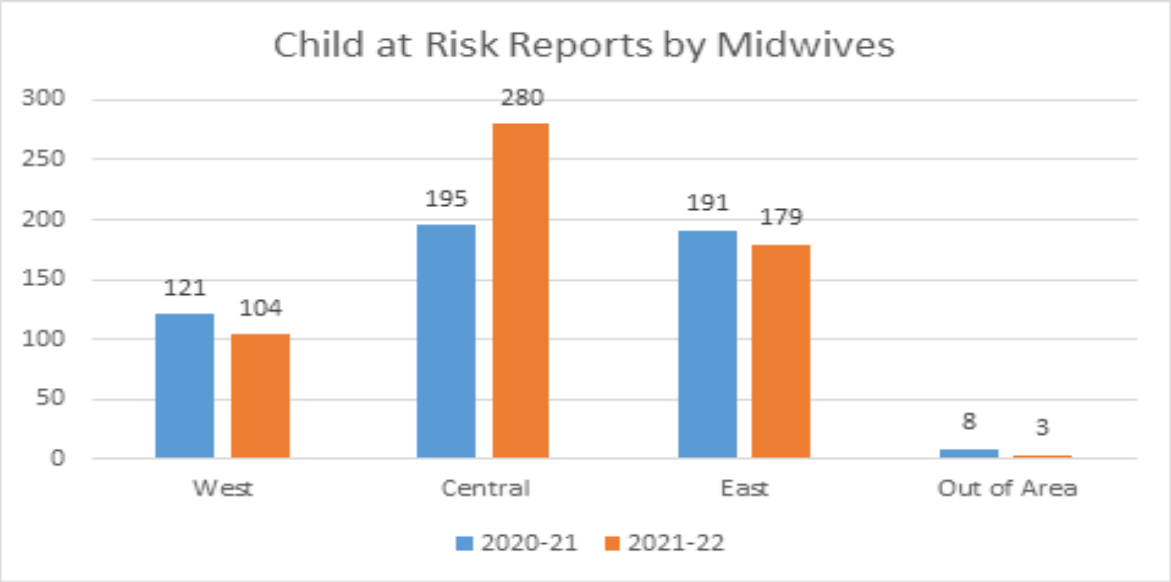
8.8.2 Midwives were responsible for the highest proportion of reports in the Central area, followed by East and West.

8.8.3 As is consistent with previous years, East and Central continue to submit the majority of At-Risk reports which demonstrates the additional resources required by the Specialist Midwives in those areas, compared to the West Specialist Midwife.

8.8.4 Based on the above, a priority action of the Corporate Safeguarding Report (2020-2021) recommended a review of the Safeguarding Midwifery provision which is covered below.

8.8.5 The below table demonstrates the trend in reports submitted for unborn babies in the last reporting period, compared to this reporting period (2021-2022). There has been an increase overall by 17.6% (n=73) and a significant increase in the Central area.

Figure 9: Child at Risk Reports 2021-22 compared to 2020-21.



8.8.6 As demonstrated in the table 31 below, midwives submitted 566 Child at Risk reports during the reporting period. Reports from midwives accounted for 15.5% of all Child at Risk reports across the region and midwives were the 4th highest category of referrers across BCUHB.

Table 31: **BCUHB wide Child at Risk Reports highlighting Women's.**

Designation of Referrer	Reports	Proportion of Reports
Emergency Department	906	24.9%
Other	759	20.8%
Health Visitor	666	18.3%
Midwife	**566**	**15.5%**
CAMHS	423	11.6%
School Nurse	107	2.9%
GP	84	2.3%
Children's Ward	74	2%
SMS	46	1.3%
Not Recorded	11	0.3%

8.9 Corporate Safeguarding Midwifery Service Review (2021-2022)

8.9.1 The Corporate Safeguarding Annual Report 2020-2021 recommended a review of the Safeguarding Midwifery provision. This was based on data relating to Child at Risk reports highlighting inconsistencies across the region.

8.9.2 The terms of reference and methodology was devised and taken through the governance processes in both the Womens Division and Corporate Safeguarding. Full engagement of staff for this review was a priority and so both qualitative and quantitative data is being collected.

8.9.3 The quantitative and qualitative data collection was completed at the end of March 2022, with the analysis and final report being due early within Q1 of 2022-2023. There was a slight delay given the COVID-19 pressures within divisions and staff absences during the winter months.

8.10 Midwifery Safeguarding Ambassadors

A bespoke Safeguarding Ambassadors package was developed with the support of the Safeguarding Practice Development Lead. The inaugural session was delivered at the end of September 2021 and 4 Midwifery Ambassadors were trained. This brings the total number of Midwifery Ambassadors to six. The West area currently does not have any Ambassadors so will be a priority area for the next session which is planned for Q1 of 2022-2023.

Priority Action 31 (2022-2023).

Increase Safeguarding Ambassadors within the maternity settings.	March 2023

8.11 Midwifery Patient Stories

A pregnant woman was 18 weeks pregnant with her third child when she booked for maternity care. Her other two children are placed in the care of the local authority for concerns related to neglect and domestic abuse. She had been diagnosed with global developmental delay and her partner had diagnoses of Attention Deficit Hyperactivity Disorder, Dyspraxia, Hydrocephalus, Learning Developmental Delay. Her partner was not the father of the unborn.

Domestic Abuse is also a feature within this current relationship however Routine Enquiry into Domestic Abuse had not resulted in any disclosures.

The parents were deemed to be vulnerable adults with no support and were demonstrating that they are finding it difficult to cope on their own.

Midwives are immediately concerned that the unborn is at risk of neglect/ emotional harm.

Due to her learning needs, all midwifery appointments were face to face, at home, by the same midwife, evidencing person centered care. A Health Pre Birth Assessment was undertaken in a timely way and Child at Risk report submitted.

The woman was referred for an advocate to support her which was provided. This role proved vital in ensuring that her needs were articulated to staff, particularly whilst admitted to maternity around the time of the birth.

An initial child protection conference was held given the concerns of significant harm and the unborn was to be placed on the Child Protection Register at Birth. Legal advice was also sought, and the plan was for court proceedings to be initiated at birth.

A robust risk assessment was formulated by health to ensure that the family and staff were safe given the risks that were posed and the complexity of the family situation.

Following the birth of the baby, the woman was supported by maternity staff in the care of her baby and with parenting skills. She disclosed domestic abuse and support services visited her on the ward however she subsequently retracted her allegations.

Mother and baby remained on the ward for 11 days, as the initial court hearing was contested, and no decision could be reached regarding an Interim Care Order. Interim Care Order was granted on day 11 and the baby was removed into foster care The parents were given contact with the baby in the community and were supported by midwifery staff until baby was 28 days old.

A referral to the Reflect service in the Local Authority was made. (Reflect support women who have had babies/children removed from their care to address presenting issues and concerns and ensure engagement with support).

A BCUHB Antenatal Clinic Midwife contacted the Specialist Safeguarding Midwife for ad hoc safeguarding supervision in relation to the transfer of a pregnant woman, initially booked to deliver her baby at Shrewsbury and Telford Hospital.

The Midwife advised that a woman had transferred her care to Wrexham Maelor at 36 weeks' gestation. On the Booking Risk Assessment completed by Shrewsbury and Telford Hospital, it stated only that the other child on Child Protection register, and no further information had been shared.

The patient was overheard telling another patient that she had transferred her care to try to avoid further children social care involvement. On further investigation, her previous child had been removed and the Unborn's name was to be placed on the Child Protection Register. Shropshire Local Authority also advised that the case was also in Public Law Outline and the Local Authority were planning to initiate care proceedings following birth.

The Specialist Safeguarding Midwife contacted the Named Midwife for Safeguarding at Shrewsbury and Telford Hospital to highlight the case and obtain further information. This enabled the formulation of necessary risk assessments and plans. The baby was born at Wrexham Maelor hospital and there was excellent prompt liaison with the Local Authority. Care proceedings were issued, and the case was heard in court the next day.

An Interim Care Order was granted, and baby was placed in foster care from hospital. Mother was discharged back to Shrewsbury and Telford Trust and a Discharge Planning summary was shared with the Trust. Shrewsbury and Telford Hospital professionals were also invited to the discharge planning meeting.

This is an example of the need for joint working in relation to safeguarding cases and ensuring that the correct processes are in place for the sharing of Safeguarding information.

The collaborative multi agency responses, for these complex cases, as outlined above, ensured that there was appropriate escalation and safeguarding for the families involved.

Separations of babies from the care of their mothers soon after birth continues to be a challenging and emotive situation faced by both safeguarding and maternity services. As such, midwives would benefit from additional support and training in this area. Support is available to maternity staff via the Trauma Risk Management process also.

There has been work undertaken in other maternity units to implement ‘memory boxes’ that are given to women on the postnatal wards when they are involved in court proceedings for their newborn baby. This trauma informed initiative could be replicated in BCUHB and would be an example of good practice.

Priority Action 32a & 32b (2022-2023).

a) Working closely with the North Wales Reflect service, devise a training package for midwives to support and strengthen practice in the area of separation of babies from their mothers/parents	March 2023
b) Working closely with women's services, scope opportunities to implement a 'memory box' for women who are involved in court proceedings	March 2023

Appendix 3

Corporate Safeguarding Annual Report - Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) 2020-2021

1. Introduction

1.1 This Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act (MCA) 12-month report provides an overview of the Deprivation of Liberty Safeguards, Mental Capacity Act and Liberty Protection Safeguards (LPS) activity undertaken by BCUHB during 2021-2022.

1.2 The activity recorded provides oversight and organisational assurance in relation to BCUHB's statutory duty under Deprivation of Liberty Safeguards and the Mental Capacity Act.

1.3 The activity includes key actions and activities taken to ensure that Deprivation of Liberty Safeguards/Mental Capacity Act, as part of the wider Corporate Safeguarding agenda, remains paramount to services delivered across BCUHB.

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

1.5 Deprivation of Liberty Safeguards reports throughout the organisation in accordance with the Safeguarding Reporting Framework. This framework reinforces organisational engagement, reporting and escalation, by the Safeguarding Governance and Performance Group, Patient Safety and Quality Group and directly into the Mental Health and Capacity Compliance Committee.

2. Governance and Rights Based Approach

2.1 Safeguarding Governance and Reporting

2.1.1 Deprivation of Liberty Safeguards were introduced in April 2009 to provide a legal framework to vulnerable people who are or may become deprived of their liberty and is an amendment to the Mental Capacity Act 2005. The safeguards were introduced to ensure that any deprivation of liberty to a person who may lack capacity complies with the European Convention on Human Rights (ECHR) (Article 5(1)) and the Human Rights Act (HRA) 1998 (Article 5). The Human Rights Act states that; "Everyone has the right to liberty and security of person. No one should be deprived of his or her liberty [unless] in accordance with a procedure prescribed by law" (i.e., a Deprivation of Liberty Safeguards or a Court Order). This means that if a person is deprived of their liberty without an authorisation in law to do so, then it will be an unlawful deprivation.

2.1.2 The Deprivation of Liberty Safeguards framework sets out that it is the Health Board's responsibility in its role as a Supervisory Body to grant an authorisation for a Deprivation of Liberty Safeguards. This authorisation provides a legal framework and protection when a deprivation of liberty is considered unavoidable, and it is in the person's best interests for the person to be deprived of their liberty when in a hospital setting, independent hospital or a hospice registered as a hospital. This would apply where detention under the Mental Health Act 1983 is not appropriate for the person at that time.

2.1.3 The Health Board has a dual role when discharging its duties by following the Deprivation of Liberty Safeguards legislation and guidance. There are two key frameworks, the Supervisory Body, which is the Deprivation of Liberty Safeguards/Mental Capacity Act Team (part of the wider Corporate Safeguarding Team and BCUHB) and the Managing Authority, which is the Ward or Service responsible for the patient and ultimately the Executive Director, who has accountability for the delivery of the service responsible for the care of patients on the ward or unit.

2.1.4 The Supervisory Body's function also provides a strategic role for those approved to be 'Authorisers' formerly known as 'Signatories' within the Division to grant a Deprivation of Liberty Safeguards.

2.2 Deprivation of Liberty Safeguards Audit, Quality and Assurance activities and findings

2.2.1 Deprivation of Liberty Safeguards applications are prioritised according to the risks and urgency identified within the application and the accompanying documentation (Capacity Assessment, Care Plan or Specialist Nursing Assessment) which will be determined at the scrutiny stage when first received by the Deprivation of Liberty Safeguards/Mental Capacity Act Team recognising.

- Whether the patient objects to the restrictions in place.
- What level of restrictions are in place including 1:1 nursing, sedating medication, physical restraint or other.
- Whether the patient is in an Acute or Mental Health Unit and the level of supervision needs to be greater.
- Whether the patient is already subject to an existing Deprivation of Liberty Safeguards authorisation, which is going to expire.
- Whether there is a Court of Protection appeal or an existing Court Order in place.

2.2.2 The Deprivation of Liberty Safeguards/Mental Capacity Act Team conducted an audit of the Deprivation of Liberty Safeguards documentation completed by the Managing Authority in Q2 and Q4 of 2021-2022. The audit identified three (3) main themes that had previously been highlighted during 2020-2021.

- No inclusion of the Mental Capacity Assessment Form.
- Mental Capacity Assessments are completed incorrectly or relates to the wrong decision.

- The Deprivation of Liberty Safeguards application documentation was not completed correctly, not signed, not dated, and not dated correctly.

2.2.3 In response to the audit and the concern that the themes identified mirrored those that were previously raised, the Corporate Safeguarding Team (Supervisory Body) have further developed.

- A process of scrutiny to cross-reference incidents with Datix to target trends, provide individual supervision, and ensure reporting compliance.
- Developed a Deprivation of Liberty Safeguards Standard Operating Procedure (SoP) to reinforce the Deprivation of Liberty Safeguards Code of Practice for front line practitioners.
- Safeguarding Ambassadors have been identified throughout the organisation. A governance and supervision framework supports their activity, which is to focus upon the continued implementation of the safeguarding recommendations. This includes awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards frameworks.
- Bespoke Mental Capacity Act/Deprivation of Liberty Safeguards training continues to be delivered to focus upon the key omissions in the Deprivation of Liberty Safeguards process by the wards (Managing Authority). The training was created in Q1 using a variety of IT platforms. During Q3 and Q4 this training was adapted and amended to reflect a more interactive and practical approach and continues to be offered to key staff and services across BCUHB.
- Legal and Risk Services have been commissioned to develop and undertake bespoke Mental Capacity Act training to support and reinforce staff understanding the importance of completed paperwork and the possible implications to the patient and Health Board if not completed accurately.

2.3 Data Analysis – Deprivation of Liberty Safeguards Applications

2.3.1 Between April 2021 and March 2022 (inclusive), the Deprivation of Liberty Safeguards team received a total of 1,629 applications, see Table 1 below. This is the largest number of applications received since the Deprivation of Liberty Safeguards framework was implemented and is a 40% increase on the previous year. Over the last 4 years' Deprivation of Liberty Safeguards applications have increased annually. The introduction to the Liberty Protection Safeguards is projected to have a greater impact on applications, as a result we will see the number of applications more than double to in excess of 3000 per year. This is a direct result of changes in the legislation and BCUHB's responsibility to complete Liberty Protection Safeguards applications for individuals in receipt of CHC funding and children aged 16 and 17.

2.3.2 The increasing number of Deprivation of Liberty Safeguards applications is in accordance with the legal framework, which offers the patient protection for 7 days, or a further 7 days if an extension is granted by the Supervisory Body for an urgent application. There are significant pressures, challenges and risks associated with the responsibility of the Supervisory Body to allocate and assess all patients within the statutory 7-day time frame. The number of standard requests is minimal, between April 2021 and March 2022 this stands at just 11 applications (less than 1%).

Table 1

Year	West	Central	East	England	Other	Applications
2018-19	89	257	343	55	0	743
2019-20	177	282	483	72	0	1014
2020-21	208	322	550	82	0	1162
2021-22	251	333	925	120	0	1629

2.3.3 Prioritisation of all applications for a Deprivation of Liberty Safeguards is according to the risks and urgency identified within the application and accompanying documentation (Capacity Assessment, Care Plan or Specialist Nursing Assessment) which will be determined at the scrutiny stage when first received by the Corporate Safeguarding Team (Supervisory Body).

2.3.4 Out of the 1629 Deprivation of Liberty Safeguards applications submitted during 2021-2022 28% of them contained some issues or concerns that resulted in them being returned to the Managing Authority. In 2020-2021 the percentage was much higher at 44%. A substantial and focused awareness raising programme was undertaken during 2021-2022 and this has proven to be beneficial to staff completing the applications.

2.3.5 Applications are returned due to the following themes highlighted in 2.3.2 above.

2.3.6 Poor quality applications, resulting in legally deficient documentation provides the basis for a legal challenge.

2.3.7 The Deprivation of Liberty Safeguards Forms present the evidence necessitated by the statutory qualifying requirements in order to ensure a person's deprivation is lawful.

The errors in completing the Deprivation of Liberty Safeguards application could lead to a delay in the authorisation of a Deprivation of Liberty Safeguards, which may result in the patient been deprived of their liberty unlawfully for longer than necessary.

2.3.8 The Supervisory Body spends unnecessary time pursuing further information to support the application. To mitigate risk additional training programmes have been undertaken with bespoke training provided to wards who have a high rate of late and/or incomplete applications.

2.3.9 The increased demand of applications and the availability to meet that demand within existing Deprivation of Liberty Safeguards services remains a challenge. The figures alone do not reflect the level of complexity and demand upon the Deprivation of Liberty Safeguards service. The trend for Deprivation of Liberty Safeguards applications is an upward trajectory. An increase in the number of Best Interest Assessor's (now 6) has had little impact upon the applications waiting list. The Corporate Safeguarding Business Case has identified the need for additional clinical and administrative support.

2.4 Welsh Government Monies

2.4.1 Following the Welsh Government (WG) bidding process to secure funds to support Health Boards in their efforts to reduce what is referred to as the 'Deprivation of Liberty Safeguards backlog' and to promote Mental Capacity Act understanding and compliance across BCUHB, the Corporate Safeguarding Team secured £344,086 in total for 6 months on behalf of BCUHB.

Table 2

Urgent Applications (1 - 7 days)	20
Extended Applications (8 - 14 days)	24
Standard Authorisation (approved)	50
Allocated to BIA	14
Allocated to Section 12 (2) doctors	14
Applications under Scrutiny	7
Awaiting to be Authorised	6
Backlog	36
Total	171

2.4.2 Welsh Government identified that Health Boards and Local Authorities across Wales may struggle to enact their initial proposals due to the onset of the COVID-19 Omicron variant. To date we have:

- Completed additional Best Interest Assessments (BIAs) to tackle the current backlog of Deprivation of Liberty Safeguards applications. This was achieved by offering Best Interest Assessor's the opportunity to complete out of hours assessments.
- Strengthened the current Mental Capacity Act/Deprivation of Liberty Safeguards administration and management team.
- Reviewed current Mental Capacity Act training and adapted a 'practical' 30-minute training module with supporting information for all staff. This training is delivered across services with plans in place to deliver outside of normal working hours i.e. between the early hours to target night staff.
- Mental Capacity Act/Deprivation of Liberty Safeguards/Liberty Protection Safeguards Leads for specific areas within the organisation have been appointed and are scoping services to ascertain current levels of Mental Capacity Act understanding and the need for additional support. Leads for Secondary Care, Primary Care, Commissioning and Paediatrics are in place.
- MCA resources have been sourced with the aim to empower staff in their roles. This includes 'banner pens' Wallet sized guides for staff, patients, and families. These will also be presented in an 'easy read' format and will be available in both English and Welsh.

- All materials are in the final stages of approval and are due to be delivered in Q1 2022-2023.

2.4.3 Welsh Government were specific in their request to ensure that no Liberty Protection Safeguards work is undertaken prior to the formal start of the consultation process.

3. Safe Care

3.1 Court of Protection

3.1.1 The Team responds to and support front line colleagues when cases have been referred to the Court of Protection (CoP) for the following reasons:

- **Section 21A Challenge:** Patients have a right in law to challenge the detention if the patient feels it is unlawful. (Article 5(4) ECHR).
- **Section 16 MCA (2005):** Relating to welfare decisions.

3.1.2 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 a number of hearings. During this period, we have again seen a significant escalation of complexity in a number of Court of Protection cases. This has resulted in intensive Court of Protection activity and has required Senior BCUHB Board member attendance.

3.1.3 There are six (6) new cases, relating to a Section 21A Challenge, all of which have had the initial court hearing and four (4) ongoing cases from 2020-2021.

3.1.4 The increase in complex Court of Protection cases continues to result in additional costs to the Health Board. This includes the number of staff engaged in the process, legal challenge as a result of the recognised delay on behalf of BCUHB and to address the concerns and the directions of the Court Order. Engagement with Legal and Risk which includes, Barrister fees, Court costs, Official Solicitor costs (on behalf of P), external expert costs, and where applicable compensation to P.

3.1.5 After reviewing a number of cases, activities within the process are causing organisational challenge. To respond to this the Deprivation of Liberty Safeguards Team have developed a Section 21A Challenge Standard operating Procedure (SoP) and a Flowchart to facilitate cooperation, escalation, and coordination within the Health Board. This describes the role, responsibility, and accountability when the need arises to respond to directions of the Court.

3.1.6 The provision of additional support and guidance in relation to Court of Protection applications and compliance with Court Order directions will reduce additional costs awarded against the Health Board and importantly evidence an improved experience for the patient.

3.2 Patient Story

3.2.1 Patient A is a 74-year-old lady with an established diagnosis of Learning Disability and a history of multiple cerebrovascular accidents (Stroke) leading to both physical and mental health consequences. Patient A was admitted into an acute hospital after repeated vomiting leading to aspiration and chest sepsis.

3.2.2 A Deprivation of Liberty Safeguards application was submitted, and an assessment was subsequently undertaken. The Deprivation of Liberty Safeguards was then authorised to ensure Patient A was accommodated under a legal framework.

3.2.3 Patient A required a package of care to be able to return to her home and until such time as an appropriate care package became available a best interest decision was made for Patient A to remain in hospital to ensure her needs were being fully met in a safe environment.

3.3 Case Learning

3.3.1 Due to the pressures of COVID, staff shortages and a ‘backlog’ of Deprivation of Liberty Safeguards applications there was a delay in the Deprivation of Liberty Safeguards Authorisation being granted resulting in an unlawful deprivation for 63 (sixty-three) days.

3.3.2 The case highlighted the lack of resources within the current Deprivation of Liberty Safeguards service and the potential for patient A to have made an application to the Court or Protection be awarded damages due to the delay in authorisation.

3.3.3 As a result of the delays and following application of the Welsh Government funding the Deprivation of Liberty Safeguards team completed Best Interest Assessments 7 days a week over a 6-month period. This resulted in a reduced ‘backlog’ that stood at 114 applications but having been reduced to just 36 in Match 2022.

3.3.4 Due to the delay in the implementation of Liberty Protection Safeguards the Welsh Government have agreed to provide further funding to support Deprivation of Liberty Safeguards activity to mitigate the risk of unlawful deprivation.

3.4 Assessment and Analysis

3.4.1 The delay in Deprivation of Liberty Safeguards authorisations is a national issue, BCUHB secured additional Welsh Government funding to expedite the ongoing challenges faced by the Supervisory Body.

3.4.2 In addition, the impact of COVID-19, specifically the Omicron variant towards the end of 2021, resulted in additional assessment and authorisation delays due to staff shortages.

3.5 Impact on Patient A and BCUHB

3.5.1 Patient A was unlawfully deprived of her liberty for 63 days which meant there was no legal framework in place to support Patient A being accommodated in hospital for care and treatment. As there was no legal framework Patient A was unable to legally challenge the deprivation.

3.5.2 Once the Deprivation of Liberty Safeguards authorisation was in place Patient A was supported to submit a Section 21A Challenge to the Court of Protection.

3.5.3 The Court requested evidence of why there was a delay. This was offered by BCUHB in addition to an apology. This was accepted by the Court.

4. Adverse Childhood Experiences (ACE) Informed

4.1 Rationale

4.1.1 Adverse Childhood Experiences (ACEs) such as exposure to abuse and harm, for example, sexual abuse, psychological/emotional abuse, physical abuse, domestic abuse, substance misuse and mental illness are known to have a direct and immediate effect on a child's health and wellbeing with potential lifelong consequences.

4.1.2 The safety of the child and the safety of the vulnerable adult with care giving responsibilities are intrinsically linked. With reference to the recent Supreme Court judgement for 16/17-year-olds, to detain a young person unlawfully can have adverse consequences. Preventing early exposure can reduce the impact on children and future generations**.**

4.1.3 Under Liberty Protection Safeguards 16/17-year-olds will be subject to the same legislation and legal framework as adults. Work is underway to support Paediatric services and ensure that they are prepared for the change in legislation.

5. Learning Culture

5.1 Training

5.1.1 Safeguarding training compliance is a key target for Corporate Safeguarding. An increase in compliance is reported during 2021-2022, see Table 2 below. It is recognised that no face-to-face training is taking place due to COVID-19 restrictions; however, safeguarding training continues to be available on e-learning and digital platforms and is supported by a revised virtual program to encourage ongoing training during this period.

Table 3

Training Module	March 2021	March 2022	Trajectory
MCA – Level 1	74.0%	76.5%	↑
MCA – Level 2	75.4%	77.0%	↑

5.1.2 Online Mental Capacity Act Level 1 and 2 training is available for all staff. The recent drop in compliance was reviewed with actions taken to remind staff to check their ESR mandatory training requirement in relation to Mental Capacity Act. Reminders are provided by using a variety of resources, for example, respective Safeguarding Forums, PTR meetings and the monthly Safeguarding Bulletin.

5.1.3 The dissemination of Mental Capacity Act booklets is complete, this was a key action for 2021-2022. The Mental Capacity Act/Deprivation of Liberty Safeguards booklets are available to support staff who are unable to access IT equipment or attend online training. The booklets ensure all staff are given the opportunity to complete essential mandatory training to improve awareness and processes compliance.

5.1.4 During 2021-2022 the Team completed 12 (1 each month) Deprivation of Liberty Safeguards training sessions across BCUHB. In total 893 staff attended bespoke training. In addition, the team provided bespoke Deprivation of Liberty Safeguards training at Bangor University (via teams) for 170 students. We continue to promote and offer sessions on a ward/team basis where there is targeted intervention due to reduced compliance, or when complex cases support reflective learning or where issues are raised due to audit or compliance challenges.

5.1.5 Deprivation of Liberty Safeguards and Mental Capacity Act awareness training is also included within the mandatory Adult Level 2 Safeguarding Module. The current competency rate for Level 2 training across BCUHB stands at 83.01%, which is a slightly increased position.

5.1.6 Deprivation of Liberty Safeguards and Mental Capacity Act training and the recording of compliance was included within the Corporate Safeguarding Bulletins to ensure organisational engagement and compliance.

5.1.7 To ensure accuracy and targeted training data is on ESR, work has commenced to cleanse the data and identify competencies in line with the Adult Safeguarding: Roles and Competencies for health Care Staff. This activity is completed in the MHLD Division.

5.1.8 Bespoke and issue specific Deprivation of Liberty Safeguards training, following the methodology of a 30-minute workshop, has targeted areas of low compliance or where audit activity identifies the need for greater awareness and improvement. This is because the compliance data does not always correlate with evidenced clinical practice.

6. Multiagency Partnership Working

6.1 Liberty Protection Safeguards (LPS)

6.1.1 The law relating to the Mental Capacity Act 2005 changed in May 2019 and is recognised as the Mental Capacity (Amendment) Act 2019. This new Act will change the Mental Capacity Act Code of Practice and Deprivation of Liberty Safeguards to create new statutory regulations known as Liberty Protection Safeguards. A new Code of Practice and regulations to accompany the Act were due to be in place by October 2020; however, this is now delayed with no implementation date provided by UK and Welsh Government.

6.1.2 On the 17th of March 2022 the Welsh Government published the consultation on the Liberty Protection Safeguards draft Regulations for Wales. The consultation will last for 16 weeks. A Mental Capacity Act/Liberty Protection Safeguards 'working' group to address and engage in the consultation programme is in progress and will include all key BCUHB stakeholders.

6.1.3 BCUHB can now actively progress the BCUHB Liberty Protection Safeguards Strategic and Operational Implementation Groups, a date has been set for June 2022. Oversight and reporting will be by the Safeguarding Governance and Performance Group.

6.1.4 Additional monthly Safeguarding Mental Capacity Act/Liberty Protection Safeguards Bulletins will be shared from May 2022 onwards to provide real time updates on the consultation process and the implementation of Liberty Protection Safeguards. The Deprivation of Liberty Safeguards/Mental Capacity Act Team have developed a consultation plan to review the documentation and will engage with key internal stakeholders in April/May 2022.

6.1.5 In addition, the UK Government is consulting on the 'Liberty Protection Safeguards Draft Regulations for England' and the 'Liberty Protection Safeguards Draft Code of Practice for England and Wales'. This consultation will follow the same 16-week period and will be included within the BCUHB implementation work programme.

6.1.6 The key changes to current Deprivation of Liberty Safeguards legislation are as follows:

- The Liberty Protection Safeguards will replace the Deprivation of Liberty Safeguards.
- The new safeguards will protect people's rights and freedom if they lack the mental capacity to make their own decisions.
- Liberty Protection Safeguards will apply to 16- and 17-year-olds and be applied in all settings including people's own homes.
- Wales will have its own Regulations and Code of Practice for Liberty Protection Safeguards.

6.1.7 The implementation of Liberty Protection Safeguards will have an impact across all BCUHB services. The priority over the next 12 months is to ensure all clinical staff are compliant and are able to act in accordance with the principles of the Mental Capacity Act and have completed Mental Capacity Act training.

6.1.8 Corporate Safeguarding, on behalf of BCUHB, currently attend Local, Regional and National working groups in relation to Liberty Protection Safeguards to ensure that BCUHB remain informed of any developments.

6.1.9 Welsh Government have advised Statutory Bodies to refrain from undertaking any localised training, to await both the publication of the Code of Practice and an agreed National Training Framework which will be produced and delivered by Social Care Wales. This activity is monitored via the North Wales Safeguarding Board Training Group.

6.1.10 Following the consultation period, the Mental Capacity Act 2005 Code of Practice including the Liberty Protection Safeguards will need to be brought before Parliament for 40 days. Once the Regulations are in place the necessary training for the role of the Approved Mental Capacity Professional (replacing the role of the Best Interest Assessor (BIA) will need to commence at the earliest opportunity to allow at least six months to plan for implementation.

6.1.11 The Health Board are awaiting instruction from Welsh Government with regards to the funding strategy for the Liberty Protection Safeguards.

7. Risk Management and the Corporate Risk Register

7.1 Mitigation of Risk

7.1.1 The increase in Deprivation of Liberty Safeguards applications and complexity of cases continues to be a recognised risk for the Health Board. The service delivery of Deprivation of Liberty Safeguards has several stages, all must be lawfully actioned. The mitigating activities and the ongoing implementation of improvements driven by data and activity will require resource.

7.1.2 Over the next six (6) months further work will be actioned as part of a Liberty Protection Safeguards implementation programme. Co-production and engagement with BCUHB services and divisions will support a smooth transition to support the implementation of Liberty Protection Safeguards and offer assurance that the Health Board is compliant with legislation and process in response to the proposed implementation date which commences on 1st of April 2022.

7.1.3 In addition, work will be undertaken with partner agency, third and voluntary sector organisations to ensure a smooth transition.

7.1.4 The risks associated with the Deprivation of Liberty Safeguards were presented at QSE on the 8th of September 2021 and resulted in the approval of the Risk to be included within the Tier 1 Corporate Risk Register.

7.1.5 Mitigating activities are in place to reduce the risk and improve service delivery across the Health Board. A targeted approach is required based upon trends, themes, incidents, and data and these include.

- The Deprivation of Liberty Safeguards/Mental Capacity Act Standard Operating Procedure, this is in place to provide additional guidance and direction to support the actions required for a Deprivation of Liberty Safeguards application to be authorised to prevent unlawful deprivation.
- We have increased the number of Authorisers across the Health Board.
- The Corporate Safeguarding Deprivation of Liberty Safeguards/Mental Capacity Team have delivered bespoke Mental Capacity Act/Deprivation of Liberty Safeguards training to focus upon the key omissions in the Deprivation of Liberty Safeguards process by the wards.
- Implementation and the development of revised Deprivation of Liberty Safeguards/Mental Capacity Act practical training packages, booklets, and events to support the application of learning to support care is in place.
- The scrutiny of applications is conducted by the Deprivation of Liberty Safeguards/Mental Capacity Team and includes both the Deprivation of Liberty Safeguards Form 1 and supporting documentation, to ensure evidence is lawful and the individual lacks the capacity to consent to be 'accommodated' in hospital, which is a vital aspect of the patient care pathway.
- A 'Sample' Mental Capacity Assessment Form is available and provides enhanced guidance. This best practice guidance is included in all Mental Capacity Act/Deprivation of Liberty Safeguards training and is routinely disseminated to ward staff.

7.2 Risk Analysis

7.2.1 The risks associated with the Deprivation of Liberty Safeguards are included within the Tier 1 Corporate Risk Register.

7.2.2 **Risk ID 2548**. The increased level of Deprivation of Liberty Safeguards activity may result in the unlawful deprivation of patients.

7.2.3 This may be caused by the increased number of patients who are refusing admission or who have mind altering diagnosis which reduces their capacity and cannot consent to their continued admission in an NHS hospital setting (meet the legal framework).

7.2.4 This is due to the Case Law, P v Cheshire West Council (see Legal and Compliance below) which widens the parameters of activity resulting in more patients requiring assessment for a Deprivation of Liberty Safeguards, and the Supreme High Court Judgement in September 2019 which removed the consent of parents when detaining a young person aged 16-17 years old for care and treatment within NHS settings.

7.2.5 This could lead to harm to patients from unlawful deprivation, 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.

8. Conclusion

8.1 This report provides an overview of the ongoing Deprivation of Liberty Safeguards, Mental Capacity Act and Liberty Protection Safeguards activity during 2021-2022.

8.2 In early 2022-2023 Corporate Safeguarding will present a business case to the Patient Quality Safety Group and position update in relation to the implementation of new legislation to include the Liberty Protection Safeguards.

8.3 It is envisaged the proposed new structure would provide additional assurance against specialist strategic, governance, operational and administrative activities. This is based upon the recognised activity data, and reported risks relating to Deprivation of Liberty Safeguards, Mental Capacity Act and Liberty Protection Safeguards.

8.4 All actions within the Deprivation of Liberty Safeguards/Mental Capacity Act action plan are monitored by the Safeguarding Governance and Performance Group, and the Mental Health and Capacity Compliance Committee.

8.5 The actions identified are on target and have the full engagement of the Safeguarding Quality and Performance Group membership.

Report title:	Historic Regulation 28 Actions			
Report to:	QSE Committee			
Date of Meeting:	06/09/2022			
Executive Summary:	This paper provides the Committee with an update of actions taken in response to Prevention of Future Deaths Reports received since 2016			
Recommendations:	The committee is asked to note this report.			
Executive Lead:	Dr Nick Lyons Executive Medical Director			
Report Author:	Matthew Joyes, Associate Director of Quality Dr Kath Clarke, Assistant Director of Patient Safety			
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☒ No confidence/evidence in delivery
Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:				
There is confidence in the data provided in the report, however, the confidence of historic action plan delivery cannot be guaranteed in some cases. It is important to note a new process is in place from April 2020 and this assurance rating applies to the prior process.				
Link to Strategic Objective(s):	Quality			
Regulatory and legal implications	Instances of harm to patients may indicate failures to comply with the NHS Wales Health and Care Standards of health and safety legislation.			
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	BAF21-10 - Listening and Learning			
Financial implications as a result of implementing the recommendations	N/A			
Workforce implications as a result of implementing the recommendations	N/A			
Feedback, response, and follow up summary following consultation	N/A			
Links to BAF risks: (or links to the Corporate Risk Register)	BAF21-10 - Listening and Learning			
Reason for submission of report to confidential board (where relevant)	N/A			
Next Steps: N/A				
List of Appendices: Historic Regulation 28 Paper				

Historic Regulation 28 Actions

Introduction

This paper provides the Committee with an update of actions taken in response to Prevention of Future Deaths Reports received since 2016 and builds upon the information provided last month in a QSE private session interim report on July 5th 2022.

Background

Her Majesty's Coroner is responsible for investigating any deaths which occur suddenly, or which cannot, for whatever reason, be certified by a doctor. Coroners are judicial office holders. They are completely independent and are appointed directly by the Crown. They have qualifications and substantial experience as a lawyer, a medical doctor, or sometimes both. Each Senior Coroner has a jurisdiction and usually appoints one or more Assistant Coroners or Area Coroners. These serve either full or part-time, usually while continuing work as solicitors, barristers or doctors. They are qualified in the same way and have all the same powers as a Senior Coroner when it comes to dealing with deaths and inquests.

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Prevention of Future Deaths Report because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013.

The report is sent to the people or organisations who are in a position to take action to reduce the risk. They then must reply within 56 days to say what action they plan to take.

Process for Notices from 2016 to 2020

Under the process in place at the time (now changed), the Concerns Hub which was part of the Concerns Department (now disbanded) recorded all notices received and responded to. A simple database was historically maintained ensuring all responses were centrally collated and responses provided in time. However, the function did not actively track and follow up evidence of those actions which was following the Health Board's governance model at the time; this was seen as a devolved activity and as such evidence of compliance was to be held locally within divisions.

As advised at the last QSE Committee, work has been underway to centrally collate and review the evidence from those historic notices. This covers 21 notices over the 4 years to April 2020, when a new process was implemented.

The following appendix provides the date of the notice, the service, the main theme(s), whether the responses was provided in time which were all signed off by an executive director (normally the Chief Executive or Executive Director of Nursing and Midwifery) and whether evidence of action plan delivery has been secured. The Executive Medical Director has taken over the Coronial process aspects of the Quality agenda pending a further review of portfolios with the appointment of a new Executive Director of Nursing in August 2022.

Summary of historic notices 2016 to 2020 (further detail is within the appendix)

Some of the notices from 2016 to 2020 have been themed:

- Hospital flow and handover delays

Between 2016 and 2019 ten notices were received identifying issues which impacted negatively on care received within the three Emergency Departments. All of the notices were responded to within the HMC's 56-day deadline and provided narrative updates on improvement work or reference to ongoing unscheduled care programmes at the time. Validation of the evidence has proven to be difficult and taking into account that a notice was served in 2022 citing handover delays, patient flow and ambulance transfer delays as issues that need addressing to prevent future deaths the impact of these actions remains questionable and assurance only limited, given the ongoing consequences of the COVID 9 pandemic and current unscheduled care performance.

- MHLD.

MHLD received three notices during 2016 and 2017. In May 2016, a notice referenced issues with the Therapeutic Engagement and Observation policy. This policy was reviewed and revised in both 2016 and 2018 and submitted to HMC as evidence for the response. The policy was due for further review in 2021 although the 2018 policy currently remains in use there is an updated version that has been approved at local level but requires additional work and an EqIA before submission to PSQG in September 2022. Although the review and revision of the policy provides some assurance the theme of therapeutic observations remains a recurrent theme, particularly within patient safety incidents and as such there is only partial assurance around the implementation of the policy.

The delay in care and treatment plan (CTP) development was raised within a notice received in September 2016. In order to improve the timeliness of development and reviews a process was developed whereby administrators send a report to managers of all the CTPs due for review, three months in advance. This process is still in place and assurance considered acceptable.

- Falls pathway

Further notices have been received that are not associated with a theme and include the falls pathways not being fit for purpose. This was raised in September 2016 and since the falls pathways has been reviewed, revised and re-launched in December 2016 and again in April 2022 following patient safety incidents and HSE inspections. To support the falls pathway implementation mandatory falls training is now included within ESR. Health Board-wide improvement work continues to focus on reducing the harm from avoidable patient falls.

- Medical records

A notice received in October 2016 was received detailing issues with medical records not being transferred with the patient. Although a narrative response was provided detailing the process for accessing medical records based on urgency of need, within the required deadline, there was no evidence or action plan identified. The Health Board continues to work to develop digital solutions

- Test results not being followed up

Histology results not being followed up was identified within a notice received in February 2017, and although not identified as a theme from historic notices three further notices have been received in July and October 2021, and May 2022 which all detail concerns of the review and follow up of diagnostic tests. A new procedure for result management has recently been developed and approved by the Executive Medical Director and communicated to services, however, a more robust and electronic system is now available a plan has been proposed for rapid piloting with a view to wider pan Health Board roll out during the year.

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- Safe discharge and district nurse referral management

The lack of procedure for safe discharge and district nurse referral management was identified in a notice received in March 2017.the action plan was reviewed and SoP had been developed which is

now outdated. Today, the implementation of the Malinko system assists with scheduling and referrals are managed via dedicated SPOAs. Assurance is acceptable.

- Second opinion for paediatrics

The action plan and evidence was reviewed which included guidance regarding obtaining second opinions on discharge decision making This is still in place and the principles are included within the junior doctors induction programme. Assurance is acceptable.

- Timeliness of investigations

The timeliness of investigations and completion of action plans was raised in a historic notice received in May 2018. A further notice was received in November 2021. Following receipt of the historic notice a weekly scrutiny panel was implemented by the Associate Director of Quality where services were held to account on the progress of their complaint and incident management. Today, this panel is not in existence but the investigation process has been revised to include daily (weekday) meetings whereby all incidents that have caused harm are discussed. Make it Safe+ (rapid) reviews are scrutinised at Assistant Director level and further investigations commissioned as appropriate. In addition, all reports are then reviewed at the Incident Learning Panel which initially assisted in improving the quality of the reports but today the focus is on issues identified, actions proposed and taken and shared learning. Datix Cymru's action module is utilised to track actions (with evidence) through to completion.

Notices from April 2020

Following appointment of the new Associate Director of Quality, a revised Inquest Procedure was implemented and a dedicated inquest function created within the Quality Directorate. This has been further strengthened, through an Organisational Change Process to create a Legal Services Team. NHS Wales Legal and Risks Services are supporting this change process through an embedded senior manager supporting the change.

The new process results in all notices and actions being logged in Datix and evidence collated to ensure delivery. This now ensures a central point of data and evidence and has been expanded since July 22 to included inquests related to Mental Health inquests

In addition, the following measures have been put in place to strengthen the inquest process:

- All case information is held within the Datix system and migration is underway to the new Once for Wales Datix Cymru Module.
- A standard operating procedure has been developed – this has been cited as best practice by NHS Wales Legal and Risk Services and the NHS Wales Inquest Managers Network. This was reviewed by the Network and key stakeholders and accepted in 2020.
- A risk assessment tool has been developed for inquests based on a risk matrix, which was adapted from another Health Board. This enables the team assess the risk according to a number of criteria (e.g. is there a serious incident? Is there a claim? Is there risk of neglect in relation to care and treatment). If the case is assessed as being high risk legal representation is instructed and relevant senior health board members are alerted The risk is monitored and reviewed throughout the process and adjusted accordingly.
- The Health Board is an active member of the NHS Wales Inquest Managers Network.

- Two Quality Grand Rounds have been held in 2022 with the coroners attending to provide training on their role and the inquest process.
- Training has been held for staff, including sessions involving the coroner.
- Witnesses are offered support on how to draft their statements and are offered pre- and post-inquest support from the Legal Services Team, the Health Board Solicitors, or from inquest buddies (staff who have experienced the process and are willing to help others).
- Inquest information is included in the Weekly Quality Bulletin and Safety Report – and a review is underway currently of reporting.
- Senior staff from the Health Board meet with the Coroners to maintain a strong working relationship.
- A monthly meeting is in place with the Executive Medical Director to look at upcoming inquests to support the timely submission of comprehensive documents and statements to the Coroner.

Additionally, the weekly Inquest Board Round is currently under review to ensure best alignment to the new Health Communities.

Work has also recently started, on behalf of the Executive Director of Nursing and Midwifery and Executive Director of Medicine, to improve how quality information is assured and triangulated. Inquest information, and actions including Regulation 28 actions, will be part of that process.

Further discussions are underway to strengthen this even further, by more closely aligning the clinical audit programme and the work of the emerging Governance Directorate in improving assurance mapping.

Once the new Legal Services Team structure has embedded, the intention is to audit the inquest process and this should provide assurance to the Committee on the current process.

Conclusion

The responses and actions plans that were submitted to HMC at the time of receiving the Regulation 28 report have been reviewed. In most cases, evidence has been seen and secured in a database that shows achievement of the action stated. However, in some cases it has not been possible to validate the evidence within the time and resource available for this work. There are many reasons for this, including the significant change in personnel making it difficult to obtain evidence. Most of these un-validated actions relate to unscheduled care pressures and ambulance handover delays. As reported in the interim report at the last meeting, the actual performance and patient experience remains poor and in many cases worse than pre-pandemic. It is proposed to carry out a risk assessment of each of the historic notifications to consider whether further work should be done in that area and also to consider whether a thematic review should take place. This work will come to Clinical Effectiveness Group (CEG) in November 22.

Appendix 1 – Part 1 (Historic Notices from 2016 to 2020)

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
Hospital flow and handover delays	26/08/16	Secondary Care ED (WMH)	• Delay in transferring from ambulance • Patient flow within hospital	Yes	Responses to these notices were provided to the coroner. These responses made narrative updates on improvement work or reference to the ongoing unscheduled care programmes at the time. It has been difficult to validate all evidence for various reasons, in particular the significant change of personnel making the follow up of actions difficult. In some cases updates to policies and procedures can be evidenced. However, as stated above, the impact of these actions is debatable given the consequences of the pandemic and current performance in unscheduled care.
	13/01/17	Secondary Care ED (WMH)	• Patient flow • Bed blocking	Yes	
	17/05/17	Secondary Care ED (YGC)	• Delay in transferring from ambulance	Yes	
	25/05/17	Secondary Care ED (WMH)	• Delay in obtaining an ambulance • Patient flow within hospital	Yes	
	07/07/17	Secondary Care ED (YGC)	• Patient flow • Long stay in ED (58 hours)	Yes	
	06/06/18	Secondary Care ED (WMH)	• Delay in obtaining ambulance • Patient flow within hospital	Yes	
	26/06/18	Secondary Care ED (WMH)	• Delay in obtaining ambulance • Patient flow within hospital	Yes	

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
	10/09/18	Secondary Care ED (WMH)	• Delay in obtaining ambulance • Patient flow within hospital	Yes	
	11/02/19	Secondary Care ED	• Handover of patient WAST and ED	Yes	
	07/11/19	Secondary Care ED	• Handover of patient WAST and ED	Yes	
	25/05/22	Secondary Care ED	• Handover delays • Patient flow • Ambulance transfer delays.	Yes	
MHLD	31/05/16	MHLD	• Therapeutic engagement and observation policy not being followed – training • Escalation of observation levels	Yes	The Therapeutic Engagement & Observation Policy was reviewed and submitted to HMC as part of the response in 2016 and in 2018. The policy was due for review in Dec 2021 although it is still in use, however, there is an updated version that has been approved within MHLD and was presented to CPPG in July 2022. Following CPPG there was further work to do on the document and the EqIA, therefore a named lead within the MHLD has been identified. The amendments will be completed prior to submission to PSQG in September. Actions that were put in place to ensure that CTPs are reviewed and developed in a timely
	07/09/16	MHLD	• Delay in CTP development • Staff capacity	Yes	
	18/12/17	MHLD	• Risk assessments • Escalation training	Yes	

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					manner are still in place and MHM administrators send a report to managers of all CTPs due for review, 3 months in advance with a view to avoiding any CTPs becoming out of date The role of county wide mental health teams in community mental health services has been reviewed and continues to cover the requirements the HMC stated within the Reg 28 from 2016 (responsibility of Care Coordinator for CTP reviews; escalation of staffing issues). This operational protocol is currently going through further revision and the latest update in the Policies Group minutes (July 2022) states that the revised protocol is dependent on the next steps of the Pathway Groups and Transformational Work. There is no expected completion date on this piece of work. It has been agreed that the revised document will be called MHLD 0055 The Role of Countrywide Mental Health Teams in Delivery Community Mental Health Services. The MHLD Supervision Guidance for Nurses and Support Workers Policy was reviewed in 2018 and again in 2021. This procedure is still active with the next review due in 2024. The action plans and evidence has been reviewed and has been completed. There are some points to note:

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					- As this is historic work, in many cases further actions have since superseded the original work. - The theme of therapeutic observations is recurring and also recurs in other areas such, as patient safety incidents which may indicate that whilst action was completed it may not have had the impact or sustainability needed.
Not associated to a R28 theme	30/09/16	Secondary Care & Area (YGC & LLGH)	• Falls Pathway not fit for purpose	Yes	The falls care pathways was reviewed, revised and launched in December 2016 and further review and launch occurred in April 2022 following recent patient safety incidents and HSE inspections. In addition, mandatory falls training is now included on ESR. The action plan has been reviewed and has been completed.
	03/10/16	Secondary Care EDs (WMH & YGC)	• Medical records were not transferred with patient	Yes	A response to this notice was provided to the coroner which detailed the following information (no action plan or evidence identified): *During the patient's stay in YGC our systems indicate that unfortunately the Wrexham casenotes were not requested for review. There are protocols in place to direct staff to request*

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					casenotes for provision to clinical teams in the event of an emergency, these are: *Where notes are tracked to the main file library or to a location within the min hospital at another BCU site, and are requested by phone during operating hours, they can be retrieved and provided in one of three ways depending upon the urgency of the request determined by the clinical team:* *1. High urgency- information within the casenotes relevant to admittance to hospital can be scanned by the Health Records staff and emailed over.* *2. Medium urgency – arrangements can be made by Health Records staff for the casenotes to be placed in a taxi which will arrive the same day.* *3. Low urgency – the casenotes can be placed on the internal transport which can take up to 4 days.* *For requests out of hours local continuity arrangements apply.* *In the anticipation of the electronic patient record which will allow instant access to patient records by authorised personnel, and whilst we remain reliant on physical paper records, the Health Records Service will undertake the following steps to ensure that staff are aware of this process and appropriate guidance is given.* • *Send out a communication across BCU, and targeted to clinical governance groups*

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					hospital management teams to remind all clinical and non-clinical staff of the procedure for requesting and obtaining case notes for patients normally treated within other hospital sites across BCUHB, including details of library service hours for each of the sites (as they do differ) so that staff are aware of resource availability and processes that are available to request and obtain records. This will be sent out in the form of a lessons learnt with a reminder on the importance of requesting patient records. • *Highlight the failure to request the notes so that appropriate action can be taken . This will be done via Datix* • *Ensure that all staff within our Health Records Service are familiar with the local area processes for notes being requested during and outside of operating hours.* • *Check and confirm that all Switchboard "recognised" on call managers have contact numbers for Heath Records manager in the event of an emergency where appropriate.* • *Ensure/ review relevant risk assessments in relation to the availability of the acute patients record are in place and up to date.* • *Share good practice and processes with all custodians of the various records types across BCUHB through the Patient records Group.*

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					It was not possible to gain evidence, however, the process for transfer of case notes remains the same.
	10/02/17	YGC	• Histology result not followed up	Yes	A response to this notice was provided to the coroner. This potentially links to issues regarding follow up of results which is detailed in the table below. There was, however, no action plan recorded and a narrative response provided. More recently in 2022 following the latest notice, a new procedure was developed and approved by the Executive Medical Director and communicated to services. A more robust, electronic solution is available and the Associate Director of Quality and Hospital Medical Director (West) (covering as acting Executive Medical Director) discussed in mid June 2022 and have proposed rapid piloting this with a view to wider pan Health Board roll-out during the year. Although it is not possible to validate evidence from the 2017 notice, the actions from the latest notice offer assurance to the Committee on the new process.
	10/03/17	WMH	• Lack of SoP for safe discharge • DN referral not received or actioned	Yes	Safe discharge checklist developed, reviewed and complete. SoP developed for management of DN referrals- this was originally to manage FAX referrals, therefore the action plan was completed however

<table>
<tr><th>Theme</th><th>R28 Date</th><th>Service</th><th>Specific Issues</th><th>Responded to within deadline</th><th>Review of action plans and evidence update</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td>this is no longer relevant, and DN referrals are now managed via SPOA in the Local Authorities and sent accordingly to CRT referral e-mail. GP referrals will come to a CRT referral e-mail which are then triaged and allocated by the team leader.

The action plan has been reviewed and has been completed but ongoing changes on an All Wales basis has resulted in the development of a national nursing specification which is currently in draft form. In addition, the recently implemented Malinko system also have priority scoring against visits on the scheduling system with priority 1 visits being the essential (e.g. insulin administration; end of life care; crisis calls).

Response times:
<table>
<tr><td>Urgent</td><td>Contact will be made with the patient within 2 hours and a visit made (if necessary within 4 hours)</td></tr>
<tr><td>Non - Urgent</td><td>Contact will be made with the patient within 24 hours</td></tr>
<tr><td>Routine</td><td>Contact will be made with the patient within 48 – 72 hours or on a stated date.</td></tr>
</table>

The section below refers to all Community Nursing Services unless specified otherwise. The way community nursing services organise themselves to achieve the two hour urgent response may vary, according to local population</td></tr>
</table>

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					need and organisation of services. The definitions for response times below are intended as guidance only, as determination of these should be based on the ***professional's clinical judgement.*** **NDN and Specialist Nurses:** To enable people to receive timely care at home, preventing unnecessary attendances or admission to hospital, specialist and district nursing services must be able to respond to urgent calls within a two hour period. This response may consist of a face to face, telephone/video triage or consultation, resulting in a management plan which meets the individual's needs. Individuals who are in the last few weeks/days of life must receive an **immediate response** to calls regarding the management of distressing symptoms and/or significant changes in the person's condition. **This response may consist of an initial triage call and/or a face to face visit**, resulting in a management plan which meets the individual's needs. A proactive approach between professionals and organisations across community/practice settings is key to maximise anticipatory planning and reduce urgent issues which could have been anticipated. The reviewing of such occurrences in team/multi professional meetings should be encouraged to understand the reasons for these

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					issues, if they could have been prevented and if any changes to practice/pathways are required. ***Where clinically triaged and agreed with the referrer***, a response of longer than 2 hours may be agreed up to a maximum response time of 4 hours for a face to face visit. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record. Community Nursing Services may develop specific teams to support the achievement of an urgent response, but this should not prevent the wider community nursing workforce from developing skills or knowledge that enable them to respond to an individual's changing condition at home or result in duplication or overlap of provision. **Non Urgent** Individuals identified as requiring non urgent nursing care must receive a face to face visit within 72 hours, unless after clinical triage and discussion with the referrer a longer response is agreed. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record. **Planned** Individuals identified as requiring planned nursing care should receive a face to face visit within 10 working days, unless after clinical triage and

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
					discussion with the referrer a longer response is agreed. This decision must be clearly communicated to the individual or carer/family and documented within the clinical record. The allocation of visits must be supported via a scheduling system for Neighbourhood District Nursing services and should be considered for specialist nursing services. Scheduling systems can support the safe and timely allocation of visits, promoting 'the right nurse with the right skills, at the right time' approach. However, services may need to consider how this information is shared with the wider multi professional team, to prevent duplication of visits and the best use of staffing resources
	31/10/17	YG paediatrics	• Second opinion for paediatrics protocol • Lessons learned not being acted upon/shared	Yes	The action plan had been completed and guidance produced for second opinions. This is still in place and being used. In addition the principles within the guidance are covered during the junior Dr induction. The Facing the Future standards have also been introduced.
	17/05/18	Corporate	• Timeliness of investigations • Action plans	Yes	A response to this notice was provided to the coroner. The PTR policy was updated at the time and weekly scrutiny meetings, chaired by the Associate Director of Quality, were scheduled. These meetings were attended by the relevant management teams supported by the governance leads.

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Review of action plans and evidence update
	09/03/20	YGC	• Recruitment of locums • Checking of references	Yes	A response to this notice was provided to the coroner. The Executive Director of Workforce and OD have provided a range of evidence. A SOP was developed and compliance is reported on a quarterly basis.

Appendix 1 – Part 2 (Recent Notices from 2020 to 2022)

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Assurance and link to existing programmes
Follow up of results	14/07/21	Secondary Care ED (YGC) Corporate	• Review/follow up of diagnostic tests • Action plans	Yes	A response to these notices was provided to the coroner. A new procedure for result management was developed and approved by the Executive Medical Director and communicated to services. A more robust, electronic solution is now available and the Associate Director of Quality and Hospital Medical Director (West) (covering as acting Executive Medical Director) discussed in mid June 2022 and have proposed rapid piloting this with a view to wider pan Health Board roll-out during the year.
	26/10/21	Secondary Care ED (YGC)	• Review/follow up of diagnostic tests	Yes	
	06/05/22	Cancer Services	• Review/follow up of diagnostic tests	Yes	

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Assurance and link to existing programmes
					In one notice, a new procedure for the SNAP protocol was developed and implemented which aligned the Health Board to TOXBASE guidance.
Clinical risk in mental health	13/04/21	MHLD	• Clinical risk assessments and timely review	Yes	A response to this notice was provided to the coroner. An audit of the action implementation is part of the audit programme.
Timeliness of investigations	09/11/21	Corporate	• Timeliness of investigations • Action plans	Yes	A response to this notice was provided to the coroner. This includes the new incident management process which is in place. The DU visited the HB to undertake an external review of the process and provided a report which offers external assurance on the internal processes. All investigation reports (that are commissioned by the Patient Safety Team) and subsequent action plans are reviewed at the weekly Incident Learning Panel (ILP). The focus of the panel is to assure quality, review actions against issues identified to ensure robust and to promote shared learning. Action plans are owned

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Assurance and link to existing programmes
					by the service and to ensure that actions are tracked through to completion the action module within Datix Cymru is utilised. A monthly spot audit is undertaken to ensure that when actions are closed that the evidence has been uploaded. However, due to operational pressures delays remain in completing investigations consistently on time.
Medication safety	14/04/22	Central Area	• Thyroxine not re-prescribed	Yes	A response to this notice was provided to the coroner and although the incident happened in Central the actions planned are on a pan BCUHB basis. The learning from this matter, including the medication review will be checked across all district nursing teams to ensure consistent practice across the Health Board. The teams will be surveyed to assess their level of compliance. This has been completed. Following this survey, all district nursing teams will develop (or

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Assurance and link to existing programmes
					review and adapt) a Standard Operating Procedure/checklist to meet the needs of their own services that provides assurance of medication reviews. This will be completed by 31 December 2022. An audit will be developed with the Clinical Effectiveness Team to enable an ongoing audit programme to provide ongoing assurance of embedded change sustainability. The local district nursing team now conducts medication reviews at every visit, which is documented and countersigned by the home manager (or their representative). The Health Board Policy (MM03) includes audit of prescribing as a standard for all nursing managers and independent prescribers. The Corporate Nursing Team has initiated a task and finish group to plan the launch of the most recent ratification of MM03 in July 2022 which will include re-education of managers and Independent Prescribing responsibilities.

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Assurance and link to existing programmes
					All ANP prescribers are required to sign an annual declaration of compliance. This is stored on a centralised database and is reviewed as part of annual performance and development appraisals. The Health Board medicines management nurses carry out audits within care homes – although this does not specifically scrutinise prescribing, it covers storage and compliance with administration in care homes identified as being in escalation at the request of the care homes team. The Health Board will undertake a review of the Medicines Policy (MM01) and other related policies to clarify the process of prescribing in community settings, including clarity around the non-medical prescribers' roles, responsibilities and follow up arrangements. This will be completed by 30 September 2022.

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Assurance and link to existing programmes
					Medication administration training will be delivered to all residential and nursing home settings. The Heads of Primary Care in collaboration with the Area Nurse Director will complete and submit a business case for the required investment. The existing IMTP bid will be escalated back to executives for consideration of regional funding. An audit of the existing rolling training programme will be developed to identify homes where training is incomplete or out of date this will include the introduction of a compliance matrix to enable training compliance to be reviewed in real time. This will be completed by 30 September 2022. A proposal has been developed (currently under review) for the Central Community Pharmacy team to work more collaboratively with the Central (Area) Community Resource Team (CRT) which will include regular structured medication reviews for

Theme	R28 Date	Service	Specific Issues	Responded to within deadline	Assurance and link to existing programmes
					nursing and residential home patients. A Welsh Government pilot project has been developed (for future implementation) with a view to community pharmacy carrying out medication reviews of patients in care homes.

Teitl adroddiad: ***Report title:***	**Infection Prevention and Control Annual Report 2021–22**
Adrodd i: ***Report to:***	QSE
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 06 September 2022
Crynodeb Gweithredol: ***Executive Summary:***	The Infection Prevention and Control Annual Report is presented as part of the Board timetable. This report relates to the period April 2021 to March 2022 and seeks to provide the Board with assurance that the organisation is meeting its statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections 2014 (the 'Code'). This report outlines our key achievements and provides an assessment of performance against national targets in relation to healthcare associated infections and antimicrobial prescribing for the year. Compared to other Health Boards, BCUHB was not an outlier for any of the six mandatory surveillance organisms. BCUHB had the lowest report rate of all the Health Boards for C.difficile and achieved a level under the set trajectory for E.coli blood stream infections. BCUHB achieved a 38.6% reduction in antimicrobial use since 2013/14 compared to a 25% trajectory. The Board is asked to note that prevention and control of infection is a high priority for BCUHB, with a strong commitment to preventing all healthcare associated infections (HCAI). However, as with all services within the NHS, the COVID-19 pandemic has impacted on the routine delivery of the work programme for infection prevention and control with priorities requiring adjustment according to competing workload pressures. Furthermore, staffing within the Infection Prevention Team was severely challenged in the latter half of the year as some key senior members left, this was exacerbated by sickness. Workload had to be re-prioritised and shared across the organisation to ensure all areas had minimal cover and a risk assessment was completed. In 2021 Safe Clean Care was re-branded as Safe Clean Care – Harm Free and strengthened to include a range of new priorities and a large-scale change programme of activities aimed at sustainable changes in BCUHB's staff belief and behaviour. The programme ran a series of 90 day improvement cycles based on learning from HCAI reviews focusing on key deliverables. This included the creation of dedicated resources on the intranet with information, news and resources and 157 Infection Prevention Champions trained across BCUHB to act as ambassadors of good IP practice. Whilst recognising the improvements made during the programme, further work is required to meet the overall aim of zero tolerance approach to all avoidable infections. Decontamination of medical devices involved in patient care is also important in preventing cross infection. A Decontamination Advisor and Sister are part of the Infection Prevention team and report on key alerts, assurances and achievements which are included as part of this report. Staff conduct twice yearly audits to provide assurance of compliance with guidance and good practice. A Welsh Government Peer visit also took place in October 2021 and concluded that the

	operational team within BCUHB takes medical device decontamination very seriously and the subject is at the top of the strategic priority list. However, it was accepted that a number of infrastructure/resource challenges have prevented progression in a number of areas.			
Argymhellion: ***Recommendations:***	Receive the Infection Prevention and Control Annual Report for 2021/22 for assurance and approve for publication.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood Cyfarwyddwr Gweithredol Nyrsio a Bydwreigiaeth / Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Rebecca Gerrard Cyfarwyddwr Nyrsio Atal Heintiau a Dadlygru Director of Nursing Infection Prevention and Decontamination			
Pwrpas yr adroddiad: ***Purpose of report:***	I'w Nodi *For Noting* ☐	I Benderfynu arno *For Decision* ☐	Am sicrwydd *For Assurance* ☒	
Lefel sicrwydd: ***Assurance level:***	Arwyddocaol *Significant* ☐ Lefel uchel o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *High level of confidence/evidence in delivery of existing mechanisms/objectives*	Derbyniol *Acceptable* ☒ Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *General confidence / evidence in delivery of existing mechanisms / objectives*	Rhannol *Partial* ☐ Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol *Some confidence / evidence in delivery of existing mechanisms / objectives*	Dim Sicrwydd *No Assurance* ☐ Dim hyder/tystiolaeth o ran y ddarpariaeth *No confidence / evidence in delivery*
Cyfiawnhad dros y gyfradd sicrwydd uchod. Lle bo sicrwydd 'Rhannol' neu 'Dim Sicrwydd' wedi'i nodi uchod, nodwch gamau i gyflawni sicrwydd 'Derbyniol' uchod, a'r terfyn amser ar gyfer cyflawni hyn: ***Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:*** Further work is required to meet the overall aim of zero tolerance approach to all avoidable infections.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	This report underpins the Board's strategic direction around delivery of services.			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	BCUHB has statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention Control Report, consisting of an overview and progress report on the Infection Prevention and Control arrangements together with other Infection Prevention and Control activities and initiatives. This year, trajectories for reducing healthcare associated infections for 2021/22 were issued in September 2021 via a Welsh Health Circular titled 'Antimicrobial Resistance (AMR)			

	and Healthcare Associated Infection Improvement Goals for 2021-22'. It set out nine improvement goals for Health Boards designed to optimise the use of antimicrobials and lower the burden of infection. Details on BCUHB's compliance with each of these improvement goals is included within this Annual Report.
Yn unol â WP7, a oedd EqlA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqlA been identified as necessary and undertaken?***	Do/Naddo *N* Not required.
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP68, has an SEIA identified as necessary been undertaken?***	Do/Naddo *N* Not required
Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan gynnwys risgiau newydd (croesgyfeirio at y BAF a'r CRR) ***Details of risks associated with the subject and scope of this paper, including new risks(cross reference to the BAF and CRR)***	Key Infection Prevention risks on the Risk Register: 1. Potential that medical devices are not decontaminated effectively so patients may be harmed. This matter is currently logged on the Tier 1 Risk Register with a score of 16. Mitigating actions currently in place include: As the Decontamination Advisor is currently on a period of extended leave, there is a staff member currently acting up into the position. Exploring with Agencies whether external appointments could be made. Looking at exploring alternative methods of decontamination for the re-usable scopes. All risks related to decontamination are being reviewed via the Decontamination group. Potential disruption to the safe delivery of decontamination service due to the ageing equipment and estate is being mitigated against by establishing contingency plans. 2. Inability to deliver timely Infection Prevention & Control services due to limited capacity. This matter is currently logged on the Tier 1 Risk Register with a score of 15. Mitigating actions currently in place include: Senior members of the Infection Prevention Team (IP) are providing support to other areas as well as their own. Staff members working remotely review policies, produce reports which in turn releases non-remote working staff to undertake clinical work. Vacant posts have been re-advertised. Internal promotions being supported by other senior Infection Prevention staff.

	3. Reduction in Public Health Wales Consultant Microbiologists. This matter is currently logged on the Tier 2 Risk Register with a score of 9. Mitigating actions currently in place include: Some locum and agency cover in place to support permanent posts. Routine authorising carried out by senior Biomedical Scientists to reduce workload. BCUHB and PHW exploring other staffing options including establishing training posts and an infectious diseases bed base to help attract future candidates.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	NA
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	NA
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori ***Feedback, response, and follow up summary following consultation***	The report was compiled with information supplied by a number of senior managers in BCUHB including those in Estates and Facilites, Pharmacy, Health and Safety, Occupational Health, the Quality Directorate, Vaccination teams, Communications, Maternity, Mental Health, the Test, Trace and Protect Service, Workforce and HMP Berwyn. It was presented at Infection Prevention Sub Group on 26 July 2022 and then at the Patient Safety and Quality Group on 8 August 2022. No further changes were requested.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	There are two risks on CRR (detail above): 1. Potential that medical devices are not decontaminated effectively so patients may be harmed. This matter is currently logged on the Tier 1 Risk Register with a score of 16. 2. Inability to deliver timely Infection Prevention & Control services due to limited capacity. This matter is currently logged on the Tier 1 Risk Register with a score of 15.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Amherthnasol Not applicable
Camau Nesaf: **Gweithredu argymhellion** ***Next Steps:*** ***Implementation of recommendations***	
Rhestr o Atodiadau: ***List of Appendices:*** Infection Prevention and Control Annual Report 2021–22 Safe Clean Care – Harm Free (SCC-HF) Annual Report – 2021/22	

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

Infection Prevention and Control Annual Report 2021–22

Infection Prevention and Control Annual Report 2021–22

Table of Contents

1.0 Executive Summary

This annual report relates to the period April 2021 to March 2022 and seeks to provide the Board with assurance that the organisation is meeting its statutory requirements in relation to the management of infection prevention and control in accordance with the Code of Practice for the Prevention and Control of Healthcare Associated Infections 2014 (the 'Code'). A requirement of the Code is that the Board receives an annual Infection Prevention Control Report, consisting of an overview and progress report on the Infection Prevention and Control arrangements together with other Infection Prevention and Control activities and initiatives.

Prevention and control of infection is a high priority for BCUHB, with a strong commitment to preventing all healthcare associated infections (HCAI) adopting a zero tolerance approach to all avoidable infections. However, as with all services within the NHS, the COVID-19 pandemic has impacted on the routine delivery of the work programme for infection prevention and control with priorities requiring adjustment according to competing workload pressures.

1.1 Key Achievements and Challenges

Key Achievements 2021/22

- Compared to other Health Boards, BCUHB was not an outlier for any of the six mandatory surveillance organisms.
- BCUHB had the lowest report rate of all the Health Boards for C.difficile.
- BCUHB achieved a level under the set trajectory for E.coli blood stream infections.
- There were no cases where CPE was thought to be acquired in hospital.
- There were 99 laboratory confirmed cases of influenza in inpatients across BCUHB (compared to just 8 the previous year) but there were no associated outbreaks.
- A new Director of Infection Prevention and Decontamination was appointed in November 2021.
- A programme of work began in the latter part of the year to update the suite of Infection Prevention Policies and protocols and good progress is being made. Policies and guidelines related to COVID-19 were changed repeatedly and disseminated quickly to keep pace with changing national guidance.
- The Infection Prevention Sub Group met formally on ten occasions in 2021/22. In December and January, as the COVID-19 pandemic peaked again, reports were still submitted and key points collated and shared with members. The Decontamination Management Group terms of reference and membership were revised and a full review of associated risks undertaken.
- The Safe Clean Care – Harm Free programme continued to drive forward improvement initiatives including:
    - Creation of dedicated resources on the intranet with information, news and resources.
    - 157 IP Champions have now been trained across BCUHB to act as ambassadors of good IP practice.
    - 'De-clutter' campaigns to improve tidiness and ease cleaning
    - Environmental improvement works including installation of more bay doors at YG, new hand wash basins at WM, improved changing facilities for staff at YG, refurbishment of maternity wards and new flooring at Colwyn Bay.
    - Improved signage in all clinical and non-clinical areas
    - Installation of new PODs to separate patients
    - Clear segregation of patients on different pathways
    - Inpatient testing regimes for COVID-19 were greatly enhanced in 2021/22 to help swift decision making for patient placement at the front door.
    - Launch of a catheter passport to help improve urinary catheter care.
    - Compulsory donning and doffing training for staff with videos.

    - Lateral flow testing introduced for visitors (alongside screening) in December 2021 to support patient safety measures.
- Inpatient rates of caesarean section wound infection in women are low, however, BCUHB continues to see infection in women at 8 to 14 days postnatal so this is being investigated further; antimicrobial sutures are being introduced and dressing protocols updated.
- The COVID-19 vaccination programme completed its first phase by 31st August 2021, followed by an autumn 'Booster' Programme. BCUHB reached its highest ever uptake in many groups including those individuals aged 65 years and over at 79.9%. This represents the 2nd highest uptake of vaccines given by Health Boards in Wales.
- There has been a successful pilot of Hypochlorus acid for enhanced cleaning of patient rooms as a safer and quicker alternative to hydrogen peroxide vapour (HPV), and this will be rolled out in 2022.
- Annual reviews of BCUHBs compliance by Shared Services of our water and ventilation systems show an improved position this year.
- A Welsh Government Peer visit also took place in October 2021 and concluded that the operational team within BCUHB takes medical device decontamination very seriously and the subject is at the top of the strategic priority list.
- BCUHB has achieved a 38.6% reduction in antimicrobial use since 2013/14 compared to a 25% trajectory.
- In 2021/22, 6325 FFP fit tests were undertaken on healthcare workers across BCUHB and fit tests are now a mandatory training compliance on ESR for all staff.

Key Challenges

- Staffing within the Infection Prevention Team was severely challenged in the latter half of the year as some key senior members left, this was exacerbated by sickness. Workload had to be re-prioritised and shared across the organisation to ensure all areas had minimal cover and a risk assessment was completed. A business case is being developed to provide an infection prevention team for the future.
- COVID-19 dominated infection prevention in 2021/22. Following a significant level 3 outbreak in YG early in 2021, an external review was commissioned and a number of recommendations made and actioned. Circulation of the more infectious Omicron variant of COVID-19 led to further peaks in cases in January and March of 2021 with an associated increase in outbreaks amongst patients and staff, but most were quickly contained.
- The Welsh Governments framework for the management of patient safety incidents following transmission of COVID-19 is being followed but by the end of March 2021, only 255 cases had been fully investigated. Additional funding has now been provided to progress this work.
- Due to high rates of absence related to COVID-19, facilities had to recruit high numbers of additional bank staff to support cleaning. Focus is now on recruitment of permanent positions to support the COVID-19 Addendum.
- The estate is ageing and non-critical ventilation i.e. in general wards and departments is generally poor and reliant on natural sources. It would take significant investment to make improvements but the use of mobile air handling units is being explored.
- There is still evidence of inappropriate prescribing of antibiotics, compliance with Start Smart then Focus Audits is poor and BCUHB has high levels of antibiotic resistance so further work is required to promote the Antibiotic Stewardship Programme.
- A number of infrastructure/resource challenges have prevented progression in a number of areas related to decontamination. BCUHB need to develop a Decontamination Strategy and planned programme of improvements.

- Medical engagement at the Infection Prevention Sub Group and at hospital infection incident reviews is poor.
- Further development of IT support and systems is required to release time to care and provide data for assurance, learning and action.
- Further work is required to enhance compliance with infection prevention and control education and training; opportunities to develop IP programmes with universities are being explored.
- Further work is required with our partners e.g. nursing homes to support them with infection prevention education programmes.

2.0 Infection Prevention and Control Governance and Delivery Frameworks

2.1 The Infection Prevention Sub Group (IPSG) is authorised by the Quality, Safety and Experience Committee and the Board to support safety throughout BCUHB by monitoring, directing and ensuring assurance of effective infection prevention arrangements throughout the Health Board; and the assurance of compliance with external standards for healthcare providers. It reports through the Group Chair, the Executive Director of Nursing and Midwifery, to the Quality, Safety Group and Experience Committee and onwards to the Executive Board. IPSG meets monthly, however, formal meetings did not take place in December and January in 20201/22 due to COVID-19 related work streams. However reports were submitted, reviewed by the Director for Infection Prevention and Control, and a summary of key points and learning circulated to members. An organogram of the full accountability arrangements can be found within Appendix 1.

2.2 Local Infection Prevention Groups (LIPGs) are established within each locality (Central, East and West) and are accountable to the Infection Prevention Sub Group, and report to the Secondary Care and Area Quality Groups. Each LIPG meets monthly and has primary responsibility for ensuring that the locality has in place and operates effective management systems for the prevention and control of infection.

2.3 Groups reporting in to the Infection Prevention Sub Group

- **The Decontamination Management Group** is accountable to the Infection Prevention Sub Group and has a remit to ensure that the decontamination of medical devices is performed safely and effectively in line with national guidance, in order to protect patients and staff from infection and other adverse events. The group meet every two months, however, due to COVID-19 related work priorities, the formal meeting planned in November 2021 did not take place.
- **The Antimicrobial Stewardship Group** is accountable to the Infection Prevention Sub Group and advises the Drug and Therapeutics Group. The remit of the group is to promote appropriate and safe antimicrobial management through a multidisciplinary approach covering all care settings in North Wales with the aim of reducing healthcare associated infections, reducing antimicrobial resistance and improving patient safety. Antimicrobials are defined as any anti-infective medicine, including antiviral, antifungal, antibacterial and anti-parasitic medications and all formulations of these, including topical agents. The group meet quarterly, however, due to COVID-19 related priorities one meeting was cancelled in 2021/22.
- **The Corporate-Led Healthcare Associated Infection (HCAI) Review Group** is authorised by the Infection Prevention Sub Group to support patient safety by monitoring, receiving and directing assurance of effective investigation of Healthcare Associated Infections (HCAIs). The group has primary responsibility for ensuring that BCUHB has in place and operates a system for the robust investigation and learning from HCAIs and outbreaks, and for providing assurance of this to the Board via the Group Chair, the Executive Director of Nursing & Midwifery. Cases for presentation

are selected based on the learning and good practice identified from individual cases and/or outbreaks to ensure shared learning across the Health Board and to prevent future cases.

- **The Water Safety Group (WSG)** is a multidisciplinary group with a remit to oversee the commissioning, development, implementation and review of the Water Safety Plan (WSP). The aim of the WSG is to ensure the safety of all water used by patients / residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. The WSG provides a forum in which individuals with a range of expertise can be brought together to share responsibility and take collective ownership for ensuring water-related hazards are identified, risks are assessed with control measures identified and monitored, and incident protocol development.
- **The Ventilation Safety Group** is a multidisciplinary group with a remit to oversee the commissioning, development, implementation and review of the Ventilation Policy in accordance HTM 03-01. The aim is to ensure the safety of all ventilation systems within the healthcare environment, to minimise the risk of infection associated with airborne pathogens. It provides a forum in which people with a range of competences can be brought together to share responsibility and take collective ownership for ensuring it identifies ventilation-related hazards, assesses risks, identifies and monitors control measures and develops incident protocols.

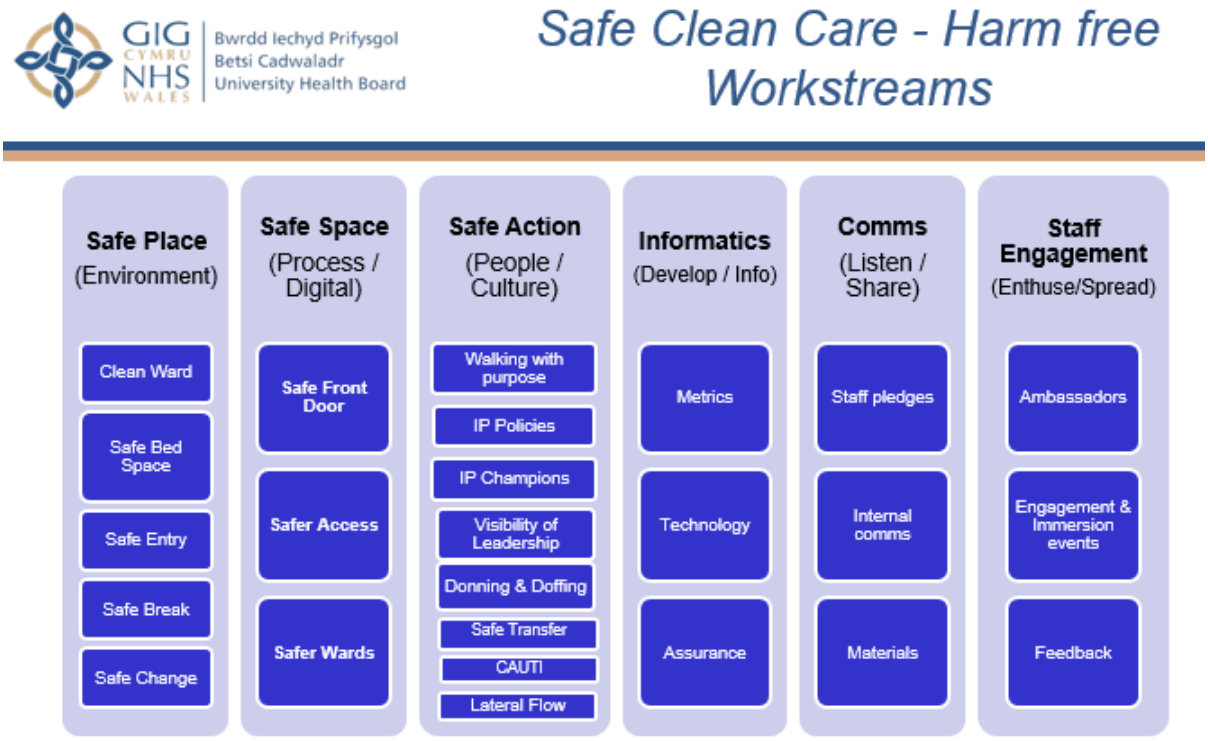
2.4 Safe Clean Care – Harm Free (SCC-HF) Project Summary

In 2018 the Health Board implemented a Safe Clean Care strategy to strengthen infection prevention leadership and assurance. Programme governance is provided through a dedicated SCC-HF Steering Group under the leadership of the Deputy Chief Executive / Executive Director of Nursing and Midwifery. Steering Group membership includes senior level staff from across the Health Board, reflecting the priority the Board is taking around this key programme delivery. The programme outcomes, risks and deliverables are reported to the Infection Prevention Safety Group.

In 2021 as part of the Health Board response to the COVID-19 pandemic, including concerns regarding other nosocomial transmission across BCU and related factors, the original philosophy was amended and strengthened to include a range of new priorities and re-branded as Safe Clean Care – Harm Free. Its aim was to have a zero-tolerance approach to HCAIs and thus a large-scale change programme of activities aimed at sustainable changes in BCUHB's staff belief and behaviour, was initiated.

From March 2021, the SCC-HF programme ran through a series of 90 day improvement cycles based on learning from HCAI reviews focusing on key deliverables. During each cycle, project activities were reviewed, on their maturity, key performance indicators (KPI's), outcomes to date and potential sustainability. These project reviews were undertaken to capture project performance, challenges faced and lessons learned. Whilst recognising the improvements made during the SCC-HF programme, further improvements are required to meet the overall aim and objectives within the organisation.

The programme was structured through enabling workstreams identified as Safe Place (Environment), Safe Space (Process / Digital), Safe Action (People / Culture), supported by Communications & Staff Engagement, Informatics and Patient Safety & Experience.



Each frontline delivery workstream consisted of a number of projects grouped into themes. Task and Finish groups were established to progress each of the projects. Each workstream was led by a Senior Responsible Officer (SRO) and supported by a limited number of specialist Programme Managers and Service Improvement expertise. Each workstream had its own PRAID (Plan, Risks, Actions, Issues and Decisions) log, and highlight reports were completed weekly during the programme initiation phase to provide continuous progress feedback to the steering group. The workstreams were developed from:

- Learning from past HCAIs
- The 'Accountable areas' 2021/22 Infection prevention plans-on-a-page
- A 40 point HARMs Self-Assessment (based on Welsh Government IPC guidance).

Many of the key deliverables from the SCC-HF project are included within this report.

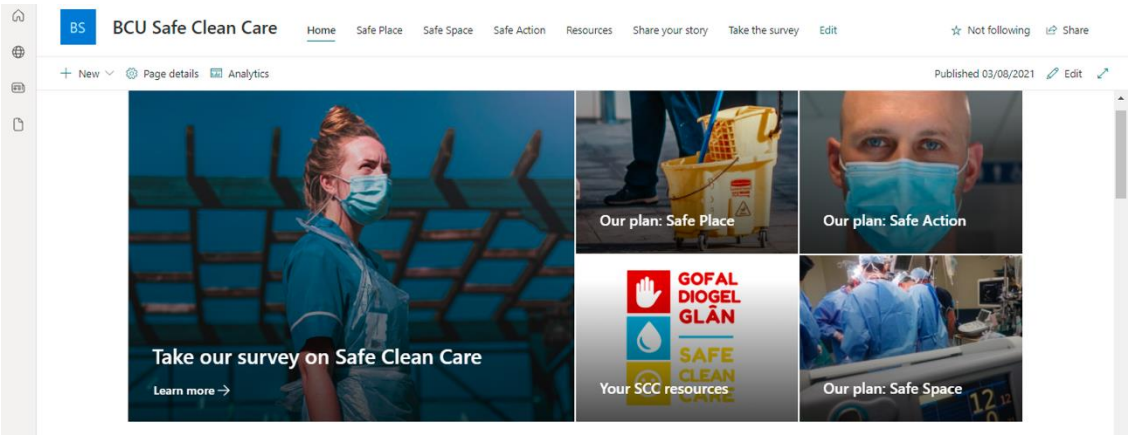
During November and December 2021, all Workstreams undertook a review of their current activities to understand their status. The category of each individual project can be found in appendix 4 and will act as a programme stage boundary informing the SCC-HF steering group as to if these activities should be; stopped, continued or modified to meet the new organisational requirements within the new operating model.

Communications support to SCC-HF

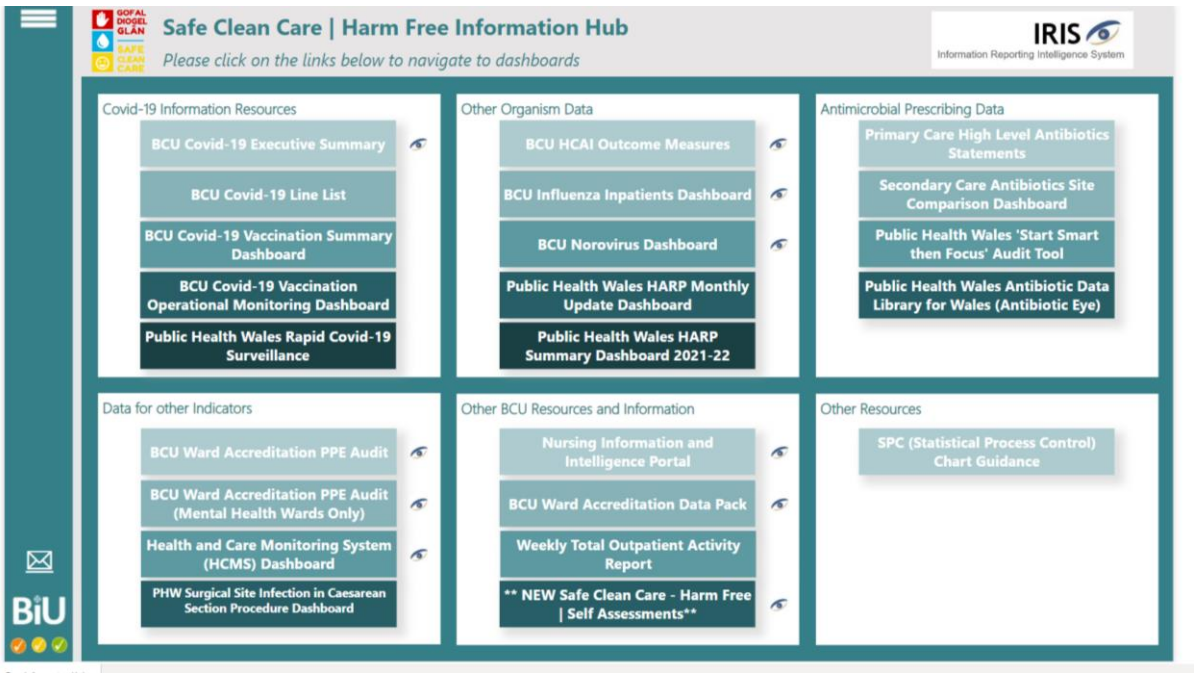
To support the delivery of the SCC – HF programme, the Health Board's communications team created a Communications Plan (approved by the board in March 2021).
Actions delivered as part of this communications plan include:

- Creation and circulation of a comprehensive staff survey, supported by IPC Champions and staff ambassadors; around 300 people from all staff groups responded with a thematic analysis of responses presented to the wider programme steering group.
- Creation of a new SCC–HF resource on the staff intranet, bringing together information, news and resources from the campaign
- A suite of programme videos including the project lead and leaders of all three Workstreams.

- Creation of a library of SCC–HF branded documents, posters and pledge cards for sharing with staff to showcase support across the Health Board.



Below is the opening page on IRIS for the SCC-HF dashboard. New sections include Weekly Total Outpatient Activity Report and Safe Clean Care Harm Free Self Assessments:



Challenges for SCC-HF

Despite the significant progress that has been made, there are certain elements that are yet to be achieved and embed as business as usual (BAU) activities. There were significant resource challenges in all of the workstreams, mainly due to dedicated staff resource not being allocated to the programme and instead staff doing it as an 'extra add-on' activity, staff leaving the organisation or moving into new roles and difficulties attracting and recruiting staff to secondments and fixed term posts.

Informatics were involved in the programme but unfortunately, they were unable to provide sufficient resource to the level of expertise that was required to enable some of the projects to progress. Many of the projects required measures and measurement systems that do not currently exist.

COVID-19 restrictions also have meant that many members of the programme team have been working remotely, therefore they have been unable to provide any onsite facilitation working with ward-based staff testing changes and implementing and embedding improvements. As a result of the COVID-19 surge in December 2021, as well as BCU's focus on the Booster vaccination programme, the SCC-HF steering group was paused from December 2021 until February 2022, which contributed to the programme being unable to achieve its aim. A variation in attendance at Task and Finish groups and the Steering group, and a lack of medical engagement has also restricted progress, and meant that some projects were unable to start.

Moving SCC-HF in to 2022/23

It is proposed that Phase 2 of the programme makes a number of modifications to align to BCU's new operating model, moving away from the requirements of a Senior Lead / SRO (Senior Responsible Officer) for each of the workstreams Safe Place, Safe Space and Safe Action workstreams, and will instead focus on embedding SCC-HF throughout BCU so that it becomes business as usual.

The new model is moving towards an integrated professional approach to support the programme, removing barriers, using champions and linking into other transformation and change pieces of work. Phase 2 will see the SCC-HF programme focus on 14 Health Care Acquired Infection (HCAI) themes that have been identified and prioritised by other staff across BCU. The SCC-HF programme will run a quarterly campaign to promote and encourage compliance with IPC guidance. Each of the 14 themes will be addressed in the following four campaigns:

- Proud of our place
- Making space safe
- Rapid learning
- Safe action saves lives

The first campaign 'Proud of our Place' is scheduled to launch in June 22 and is designed to support our wards and departments to take a greater pride in their environment.
Further detail on Safe Clean Care can be found in Appendix 5.

3.0 The Infection Prevention and Control Team

Mrs Gill Harris, Executive Director of Nursing was the appointment lead with Board responsibility for Infection Prevention in 2021/22. The Director of Nursing for Infection Prevention and Decontamination post was successfully appointed to in November 2021, which replaced the Associate Director of Nursing for Infection Prevention post that became vacant in the previous year.

Despite ongoing recruitment measures, the provision of adequate staffing within the infection prevention nursing team as a whole was particularly challenging in the latter half of 2021/22. Since the pandemic commenced, there has been a national shortage of qualified infection prevention nurses; but staffing shortages were further exacerbated in BCU by two of the three band 8b Clinical Service Leads, two Band 7s and a Band 6 leaving between October-December 2021. The Band 8b posts were unable to be filled due to lack of suitable applicants; however, a Senior Infection Prevention Nurse was employed for six months via an agency in February 2022. A review of the team structure was carried out and a decision made to advertise two Band 8a posts instead of the Band 8b's, with additional support being provided by other senior Infection Prevention staff, and these roles have now been successfully appointed to. The appointment to vacant Band 6 and Band 7 roles is ongoing with both full and part-time appointments being made. Recruitment of a suitable candidate to a new temporary Outbreak Co-ordinator role has been unsuccessful despite several advertisement attempts and positive communications to attract to the role.

Provision of adequate team staffing has been further challenged by both short-term and long-term sickness with 1,084 sickness days reported during 2021/22, equating to an average sickness rate of 10.5%. The highest sickness category related to 'stress and anxiety' with a rate of 4%. Sickness is managed in accordance with WP11 Managing Attendance at Work Policy and referrals made to the Occupational Health Department as appropriate.

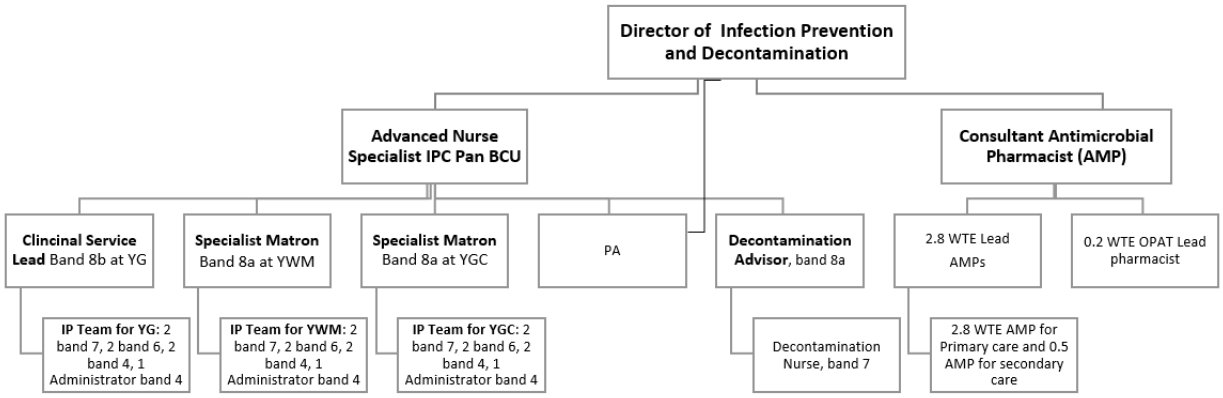
At the end of December 2021, to accommodate staff shortages, the infection prevention team's workload was reprioritised and shared across the organisation to ensure all areas had at least minimal cover and a risk assessment was completed (see appendix 2). Clinical teams were informed of the issues and the steps being taken and the Tissue Viability Team was moved to another department.

Within the Infection Prevention Team sits 2.0 WTE Decontamination staff who are specifically designated for the provision of decontamination advice across BCU; the Decontamination Advisor supported by the Decontamination Nurse.

A Consultant Antimicrobial Pharmacist reports to the Director of Infection Prevention and Decontamination. There are also 6.3WTE Antimicrobial Pharmacists supporting the antimicrobial stewardship programme reporting officially through the Pharmacy Team.

The Infection Prevention Nursing Team are further supported further by a part time Information Technology analyst who sits within the Informatics Team and a Healthcare Associated Infection (HCAI) Epidemiologist employed by Public Health Wales.

The current structure of the Infection Prevention and Decontamination Team is illustrated below.



The Infection Prevention Nurses provide routine service during weekdays 8:30-17:00 and an on call service at weekends and bank holidays from 09:00-17:00, with the on call Public Health Wales Microbiologists providing cover outside of these hours.

4.0 Public Health Wales Consultant Microbiologists

The microbiologists working within BCUHB are employed by Public Health Wales of which just 1.5 WTE were directly employed in 2021/22; with the others working as either agency or bank employees due to longstanding difficulties in recruitment. Physician Associates and Senior Biomedical Scientists support the work programme. Recruitment to current vacancies within the team is underway but with limited success and work is ongoing towards developing a microbiologist trainee programme in North Wales to attract others. A risk assessment relating to the low numbers of Consultant Microbiologists supporting BCUHB has been developed, currently scoring 9 (see Appendix 2). Discussions have been initiated for one of the substantive Consultant Microbiologists to have dedicated sessions per week to work more

closely with the Infection Prevention Team and act as pan BCUHB Infection Prevention Doctor and are ongoing.

5.0 Infection Prevention and Control Policies and Guidance

A comprehensive suite of pan-BCUHB infection prevention written control documents, e.g. policies, protocols, standard operating procedures (SOPs) and guidelines are available on the Health Board's intranet site. Infection prevention written control documents reflect relevant current legislation, Welsh and UK guidance, Welsh Health Circulars, published professional guidance and best practice. Due to competing workload priorities, Infection Prevention Team shortages and postponement of written control document approval group meetings associated with the COVID-19 pandemic, several document reviews were delayed or documents were published in draft. To address this, a structured review process was initiated to update draft and out of date infection prevention written controlled documents. The process was overseen by the Infection Prevention Sub Group and priority was focused according to the receipt of new guidance, document expiry date and Health Board need. Document reviews took place in collaboration with colleagues from other specialist services, consultation with key stakeholders and ratified according to BCUHB's approval process in accordance with 'OBS1 Management of Policies and Procedures and other Written Control Documents' and Equality Impact Assessment (EQIA) Screening requirements.

Furthermore, COVID-19 related SOP's, which formed a 'COVID-19 Toolkit', were reviewed and updated in accordance with Welsh and UK guidance and Welsh Health Circulars. A short-term approval/ratification process using the BCUHB Silver and Gold Command structure was agreed to accommodate the pace of change of national recommendations relating to COVID-19 and avoid delays in the provision of appropriate guidance to workers/employees.

6.0 Mandatory Reporting of Health Care Associated Infections

6.1 The Six Key Performance Indicators

Welsh Government trajectories were not set for 2020/21 until 28 September 2021 (Welsh Health Circular 028). A summary of performance for BCUHB in 2021/22 against the relevant HCAI Improvement Goals is described in the tables below.

Improvement Goal	Target	Current BCUHB performance 2021/22	BCU performance 2020/21	BCU performance 2019/20
C.difficile: Improvement- Reduce the annual incidence of *Clostridioides difficile* disease to 25 cases per 100,000 or below.	n~175 Rate: 25	n~215 Rate: 30.6	n~212	n~178
MRSA: Zero tolerance of preventable MRSA blood stream infections.	n~0	n~10	n~7	n~13
MSSA: Reduce the annual incidence of *Staphylococcus aureus* bacteraemia to 20 cases per 100,000 or below.	n~140 Rate: 20	n~169 Rate: 25	n~152	n~187
E.coli: Reduce the annual incidence of *E. coli* bacteraemia to below 67 cases per 100,000.	n~471 Rate: 67	n~436 Rate: 62	n~441	n~570

Klebsiella: Reduce the annual incidence of *Klebsiella* spp. bacteraemia by 10% against 2017-18 figures.	n~103	n~138	n~129	n~140
Pseudomonas: Reduce the annual incidence of *P. aeruginosa b*acteraemia by 10% against 2017-18 figures.	n~27	n~37	n~33	n~42

The table below describes the trajectories for all Health Boards in Wales.

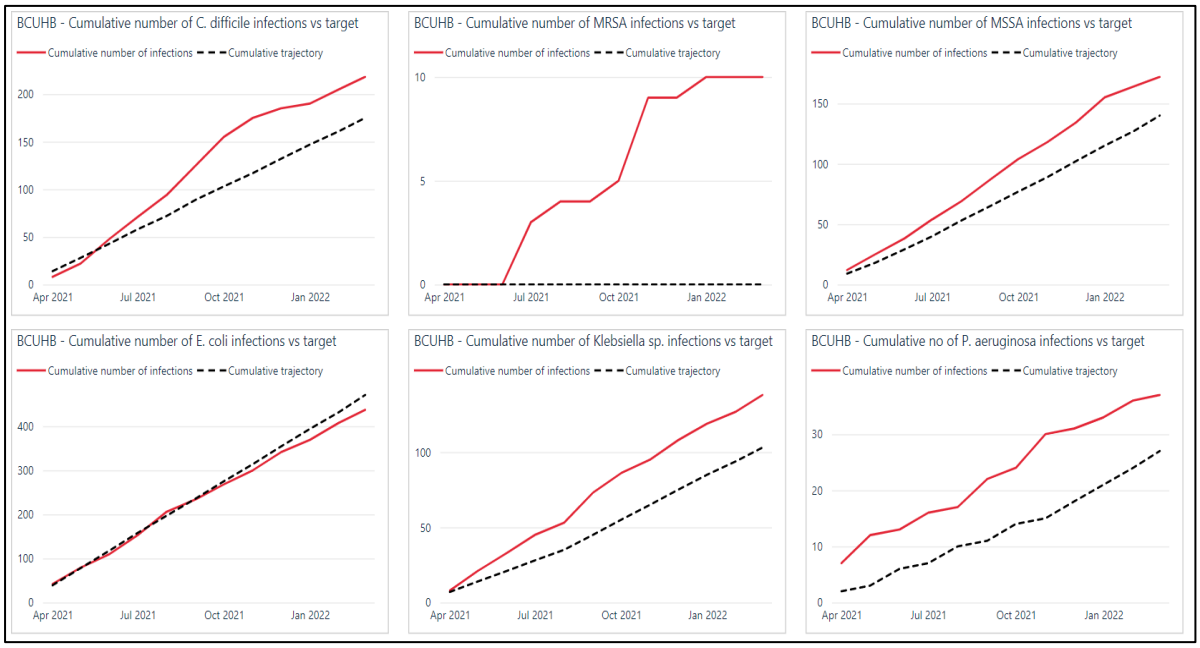
Wales 2021/22 HCAI mandatory surveillance summary, Apr 21 - Mar 22

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

Higher than same period of previous FY | Lower than same period of previous FY | Same as same period of previous FY

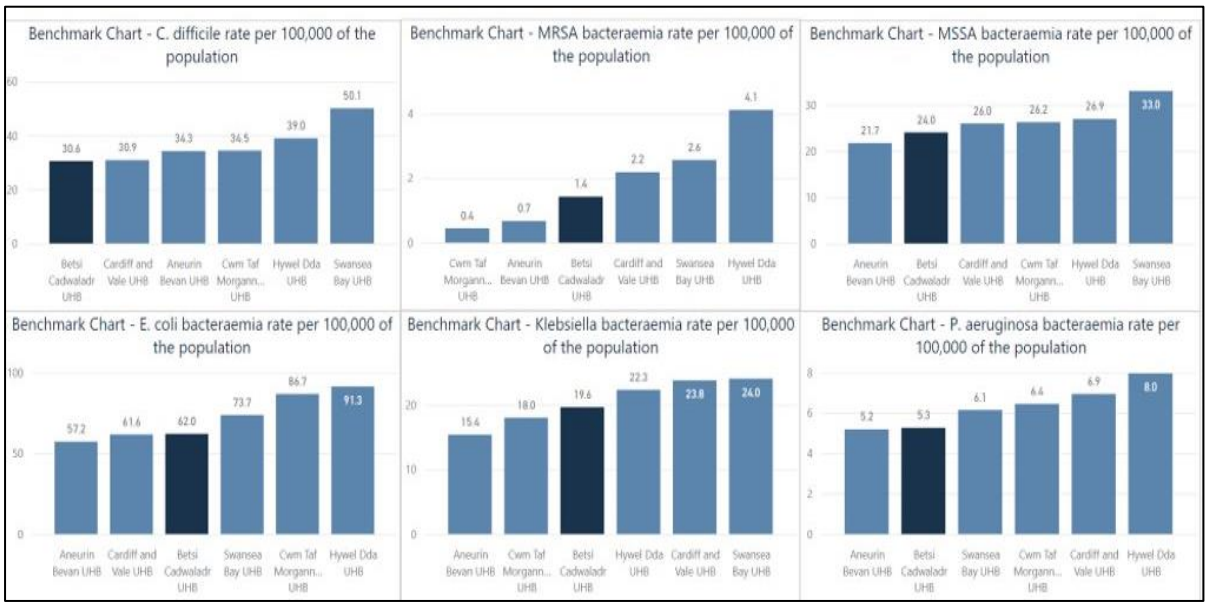
	C. difficile		MRSA bacteraemia		MSSA bacteraemia		S. aureus bacteraemia		E. coli bacteraemia		Klebsiella sp bacteraemia		P. aeruginosa bacteraemia		Gram negative bacteraemia	
	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate	Number of Specimens	Summary FY Rate
Aneurin Bevan UHB	205	34.27	4	0.67	130	21.73	134	22.40	344	57.51	93	15.55	31	5.18	468	78.24
Betsi Cadwaladr UHB	215	30.57	10	1.42	169	24.03	179	25.45	436	61.99	138	19.62	37	5.26	611	86.87
Cardiff and Vale UHB	156	30.92	11	2.18	131	25.97	142	28.15	311	61.65	120	23.79	35	6.94	466	92.37
Cwm Taf Morgannwg UHB	155	34.46	2	0.44	118	26.23	120	26.68	390	86.70	81	18.01	29	6.45	500	111.15
Hywel Dda UHB	152	39.00	16	4.11	105	26.94	120	30.79	356	91.35	87	22.32	31	7.95	474	121.63
Powys THB	11	8.27	0	0.00	0	0.00	0	0.00	3	2.26	0	0.00	0	0.00	3	2.26
Swansea Bay UHB	196	50.13	10	2.56	129	33.00	139	35.55	288	73.67	94	24.04	24	6.14	406	103.85
Velindre NHST	5		0	0.00	3		3		5		4		1		10	
Wales	1,095	34.55	53	1.67	785	24.77	837	26.41	2,133	67.30	617	19.47	188	5.93	2,938	92.69

Comparison data with organisations in England is not yet available for 2021/22 but has been requested.
The graphs below illustrate BCU Trajectories versus actual numbers of infections in 2021/22:



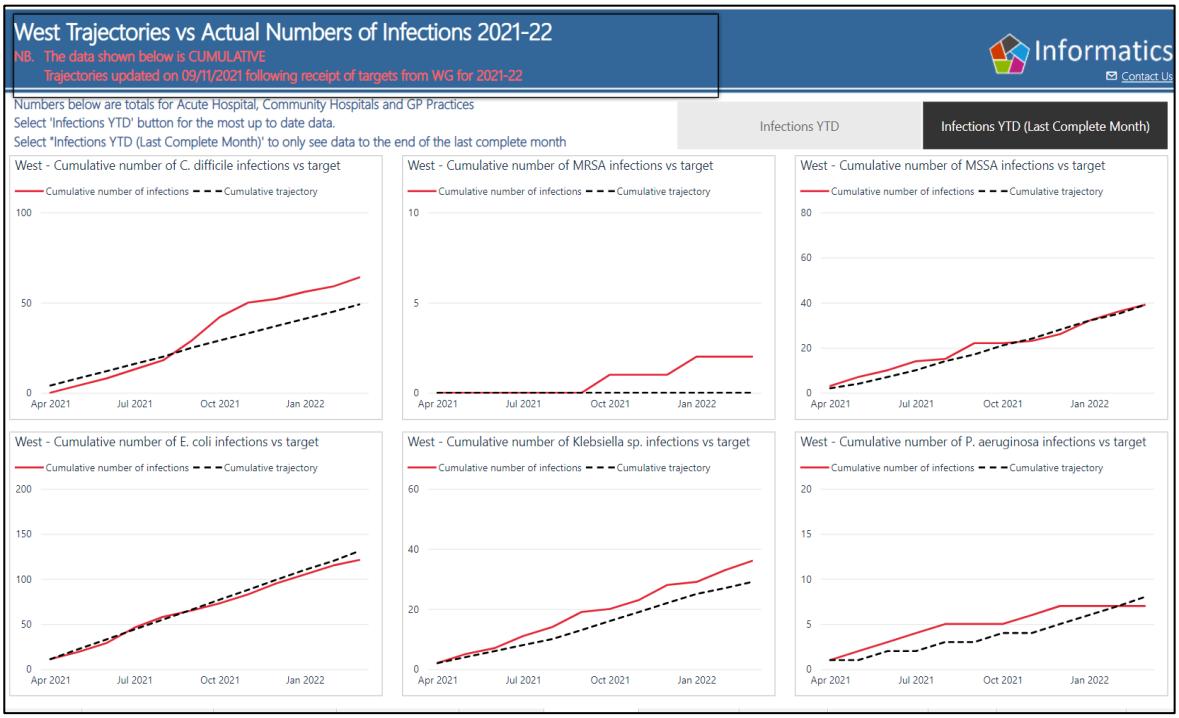
In 2021/22, BCUHB's reported cases were over trajectory for all organisms with the exception of *Escherichia coli (E.coli*), however, due to challenges associated with the pandemic, the timeframe for achieving the targets has now been extended to the end of March 2023.

BCUHB compared to other Welsh Health Boards is not an outlier for any of the six organisms with our position sitting mainly 2nd or 3rd compared to others. Furthermore, BCUHB reported the lowest rate for *C.difficile* infections in 2021/22 in Wales as illustrated below.



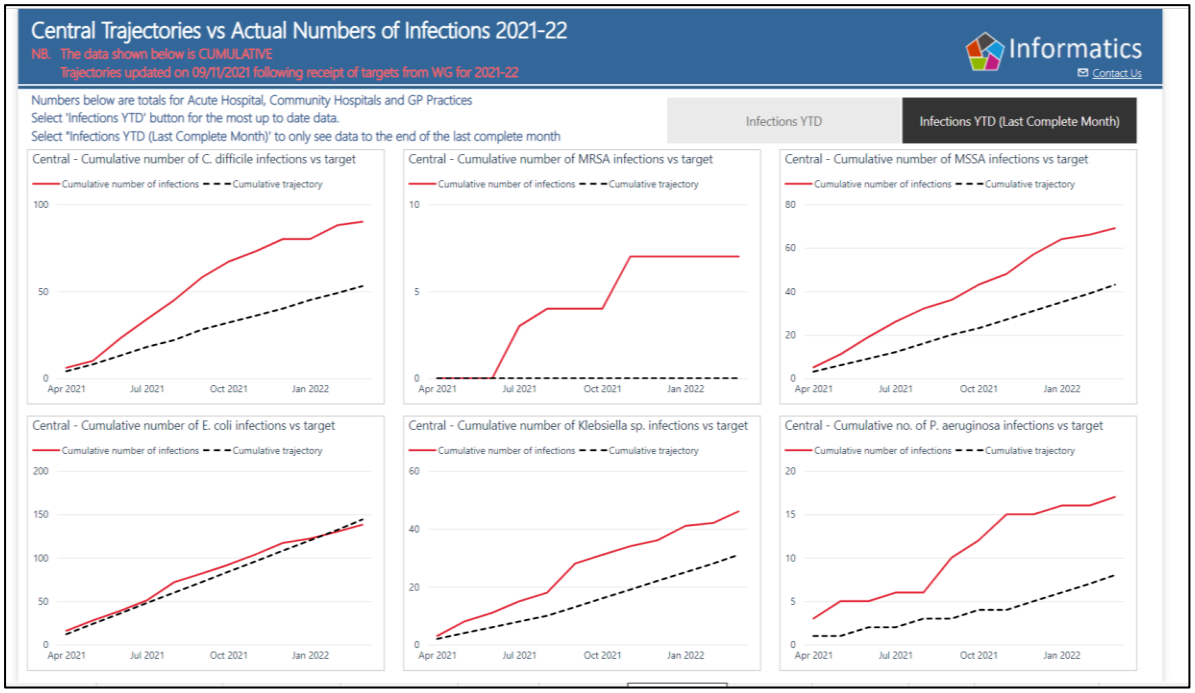
To provide further detail, compliance with trajectories in each of the three healthcare communities is illustrated below.

Data for West



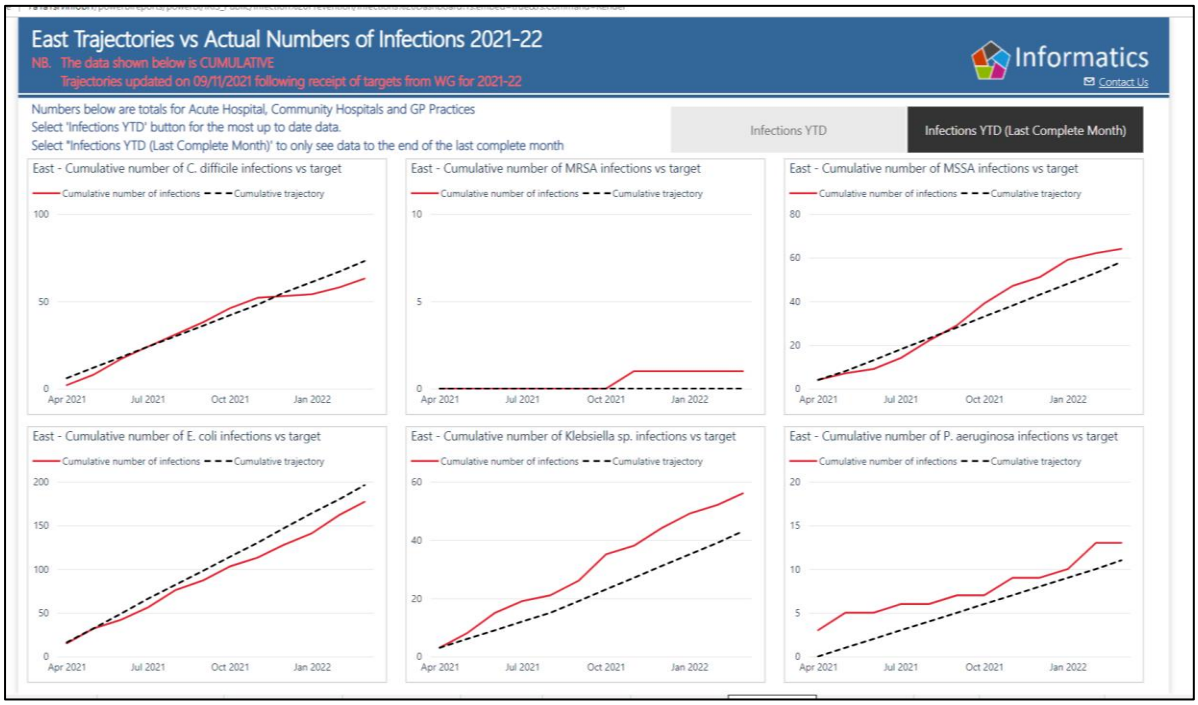
West ended the year within trajectory for MSSA, *E.coli* and Pseudomonas.

Data for Centre



Centre ended the year within trajectory for *E.coli,* but significantly over trajectory for the other organisms.

Data for East



East ended the year within trajectory for *C.difficile* and *E.coli.*

It is notable that infection rates have increased in the last few years for all organisms except E.coli. The COVID-19 pandemic has had an enormous impact on healthcare systems globally with the recognition that focusing resources that primarily mitigate COVID-19 spread, has inadvertently reduced attention to traditional infection prevention programs in terms of lack of surveillance efforts, targeted process measures and containment strategies. Infection prevention resources have been pressurised and primarily diverted to outbreak management.

The pandemic has also led to an increase in the use and overuse in some cases, of personal protective equipment, thereby potentially reducing the frequency of hand hygiene, which is crucial for successful healthcare-associated infection (HCAI) control. These factors, combined with the rapid upscaling of Intensive Care Unit capacity and patient acuity, reduced staff to patient ratios, increased patient movements, greater length of stay and higher complexity of patients is likely to have contributed to an increased risk of cross-infection of microorganisms between patients. Furthermore, high selective antibiotic pressure during the pandemic may have facilitated the insurgence of bacterial resistance. In addition, there was a lack of decant facilities within BCUHB and limited resources within deep cleaning teams to enable an uninterrupted programme of deep the deep cleaning utilising Hydrogen Peroxide Vapour within inpatient bays, to reduce the environmental load and reduce *C.difficile* spores.

Although efforts to manage the COVID-19 pandemic have understandably taken immediate priority, the impacts on traditional HCAI surveillance and prevention efforts remain concerning and requires a renewed focus to reduce them moving forwards and will be addressed within the Infection Prevention plan on a page for 2021/22 (see appendix 3).

6.2 Patient Incident Reviews

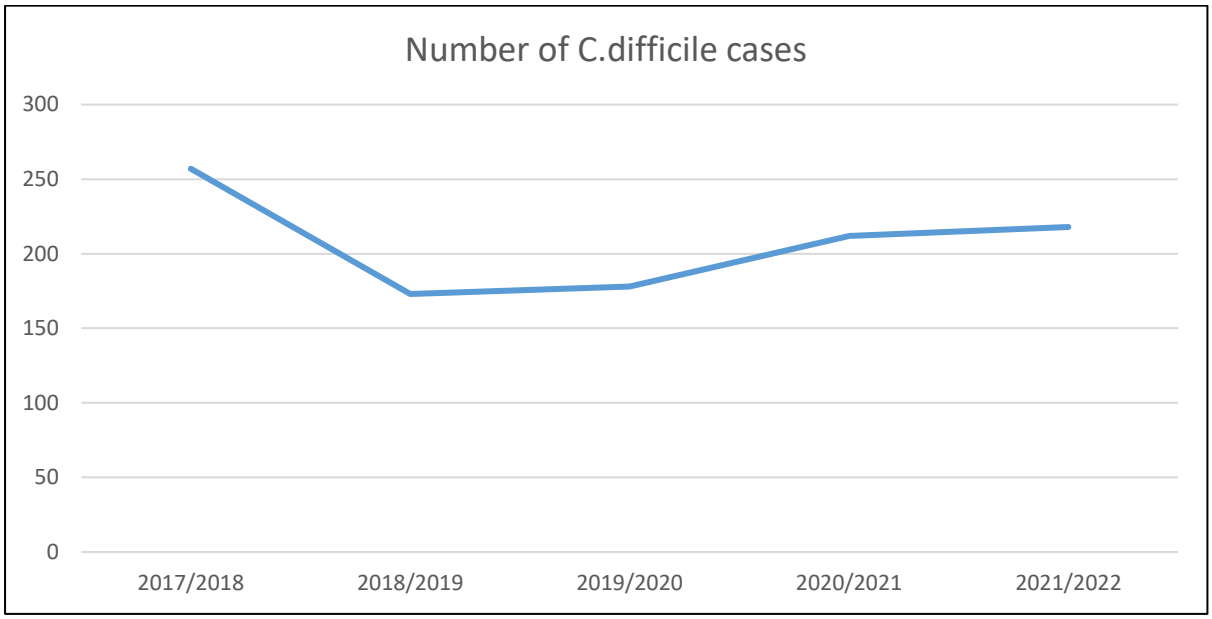
All NHS organisations are required to complete a Patient Incident Review (PIR) for key healthcare associated infections. Within BCUHB, a multi-disciplinary team meeting is convened within 72 hours of the reported result and investigation reviewed to determine if the case was unavoidable or avoidable, but medical engagement at these meetings is often poor. Action plan development addresses any required recommendations to prevent reoccurrence and enhance clinical practice, and learning is shared across the organisation. The Datix system is utilised by Ward Managers to upload the completed PIR document.
Each of the three healthcare communities selects two cases to present to the monthly Corporate HCAI Review meetings for wider learning across the organisation.

***6.3 Clostridiodes difficile* Infection (CDI)** (previously known as *Clostridium difficile)*

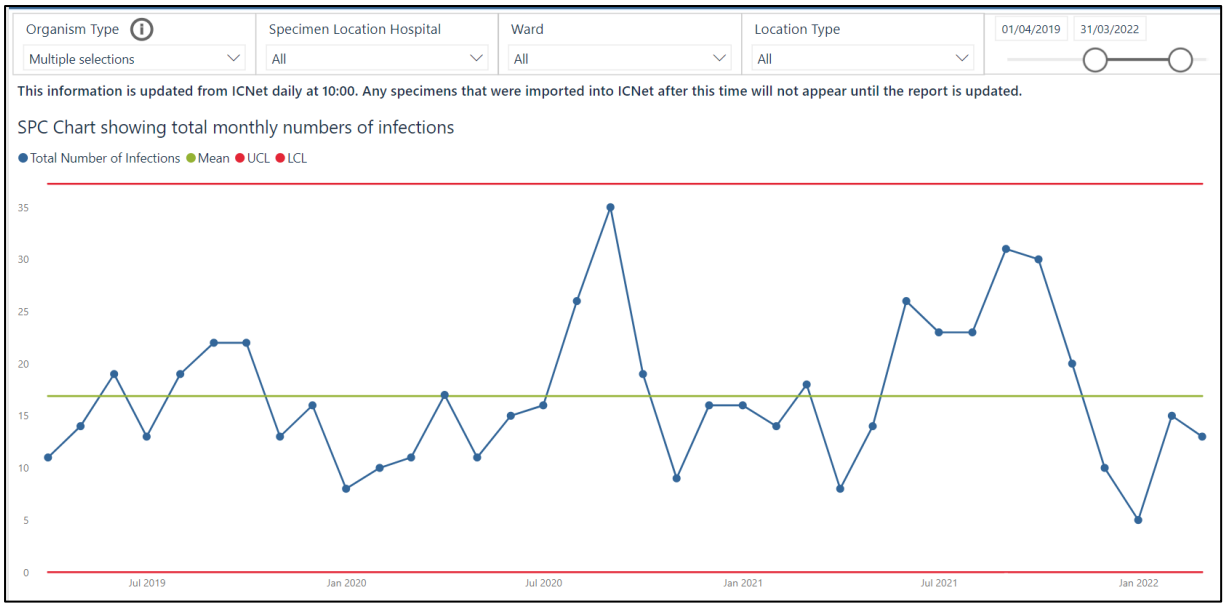
Clostridium difficile was reclassified as *Clostridioides difficile* in 2016 and shall be referred to as *C.difficile* in this report. *C.difficile* is a bacterium that is found in intestines of humans and can be found within the gut of healthy people (by laboratory testing of a faecal specimen), where it causes no symptoms (up to 3% of adults and 66% of babies). *C.difficile disease* (CDI) occurs when the normal bacteria in the intestine are negatively affected, usually by antibiotic treatment allowing *C.difficile* to multiply to unusually high levels, resulting in toxin production which attacks the intestines causing mild to severe diarrhoea. *C.difficile* can lead to more serious infections within the intestines, such as pseudomembranous colitis (severe inflammation of the bowel). *C.difficile* is the largest cause of infectious diarrhoea within hospitalised patients. Individuals become infected with *C.difficile* by ingesting the bacterium (through contact with a contaminated environment or person) and those more susceptible to infection are those who have had recent antibiotic treatment, particularly the elderly and the immunocompromised.

In 2021/22, BCUHB reported 215 cases compared to 212 in 2020/21. Whilst the number of cases is slightly higher in 2021/22 than in 2020/21, it remains lower than those reported in 2017/18 and as previously mentioned, BCUHB reported the lowest rates in Wales for 2021/22.

Year	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Number of C.difficile cases	257	173	178	212	215



An increase in CDI cases were reported during late summer 2021 as illustrated below, which is not an unusual seasonal variation, however, this has been more apparent within the last two years. In 2021/22, 22% (8/41) of CDI cases during late summer were amongst patients with a history of oncology or haematology team involvement. A task and finish group has been established to review surveillance data in greater detail to establish interventions required to reduce the risk of CDI in this patient group.



Common themes arising from PIRs of patients acquiring *C.difficile* in 2021/22 include:

- Inappropriate antimicrobial prescribing; remote prescribing in Primary Care in particular was a significant issue due to a lack of face to face consultations.

- Poor use of the Bristol Stool Chart to record patients bowel patterns.
- Delays in faecal sampling.
- Inability to perform an uninterrupted programme of deep cleaning utilising Hydrogen Peroxide Vaporisation (HPV) due to capacity, lack of decant facilities and limited resource within deep cleaning teams.
- Delays in isolating patients due to a lack of available side rooms, exacerbated by the need for siderooms for patients with COVID-19. Where siderooms were available, ensuite toileting facilities were not always available, particularly in East and West.

6.4 Staphylococcus aureus Blood Stream Infections (BSI)

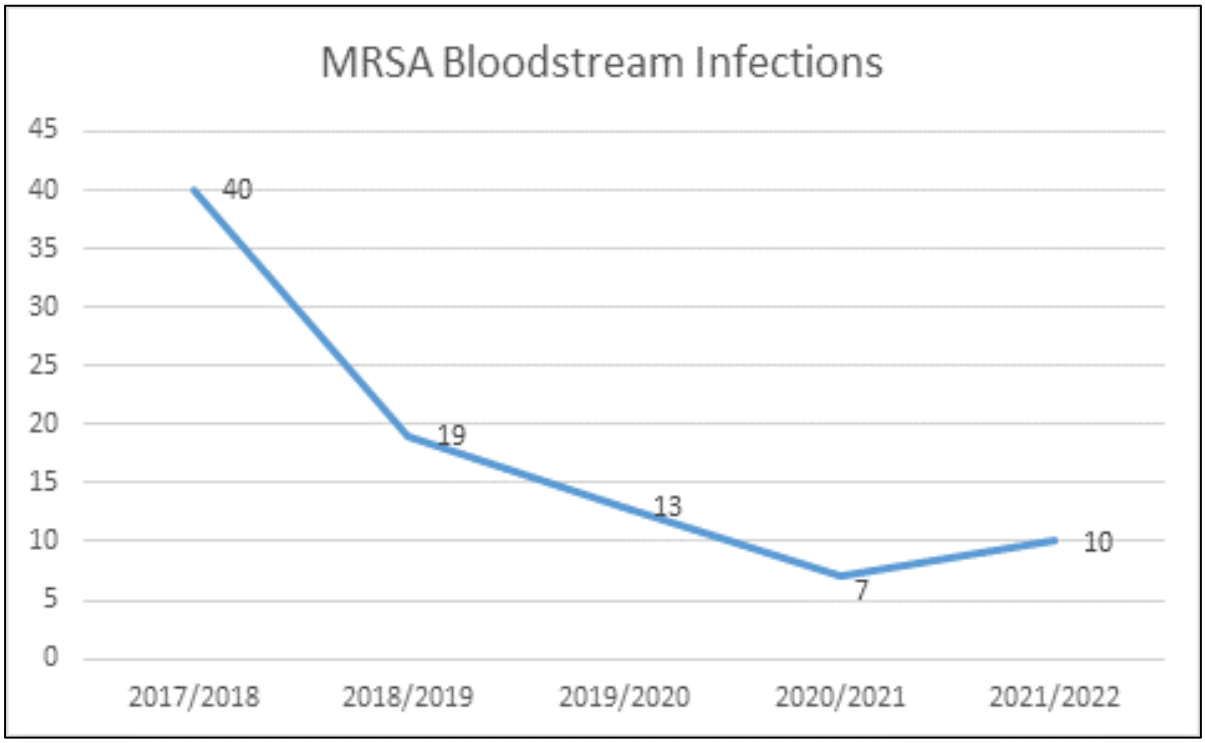
Mandatory reporting is required for all staphylococcus aureus isolates found in the blood stream (blood cultures), whether they are methicillin sensitive or resistant and whether they are considered true infections or contaminated blood culture samples. All healthcare associated cases are subject to a full patient incident review to determine the root cause and establish if it could have been avoided and identify any lessons learned.

Infection Prevention are currently working with Public Health Wales and Informatics to establish a database that will help identify the numbers and locations of contaminated blood cultures to enable more targeted training and education in 2022/23.

Methicillin Resistant *Staphylococcus Aureus* (MRSA) Blood Stream Infections (BSI)

BCUHB reported 10 cases in 2021/22 compared to seven in 2020/21, however, with the exception of 2020/21, an overall improvement is demonstrated from the position five years ago as illustrated below.

Year	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022
Number of MRSA blood stream infections	40	19	13	7	10



Of the ten cases reported, four were deemed to be avoidable with invasive devices identified as the source for the infections occurring these being; two urinary catheters, a central line and a peripherally inserted central catheter (PICC).

- Poor compliance with MRSA admission screening when patients are admitted with urinary catheters, PICCs and wounds was identified
- Incomplete documentation/care bundles associated with invasive devices
- Lack of knowledge and training outside of oncology in relation to PICCs
- Inconsistent practices associated with flushing of blocked urinary catheters
- Poor evidence of ANTT (Aseptic Non-Touch Technique) during blood culture collection and blood culture collection packs not being used

Methicillin Sensitive *Staphylococcus Aureus* (MSSA) Blood Stream Infections (BSI)
The chart below illustrates the total cases per month for the last four years from April 2018 to the end of March 2021. BCUHB reported 169 cases in 2021/22 compared to 152 in 2020/21.

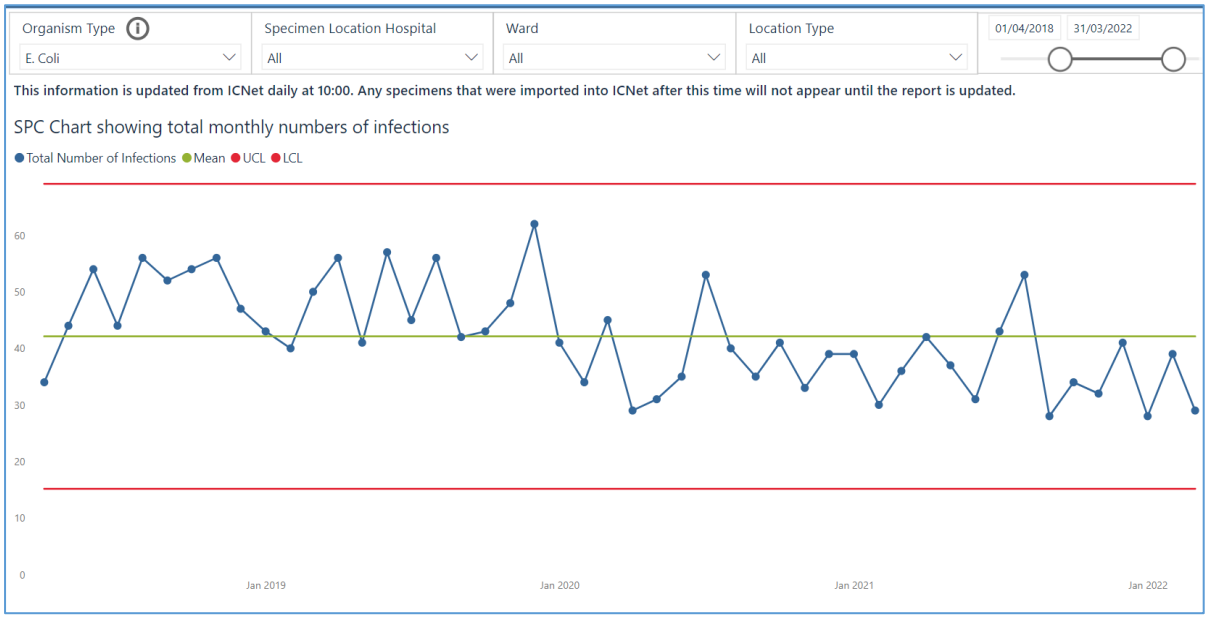
The reduction in cases across BCUHB between February and July 2020 was considered to be associated with a reduction in the number of Emergency Department attendances and therefore, a reduction in the number of blood cultures collected.
Of the cases deemed to be healthcare associated, the majority of these were device related with peripheral cannula being the most common source. Common themes include:

- Poor compliance with care bundles associated with the insertion and ongoing maintenance of invasive devices including cannula, central venous catheters and urinary catheters
- Limited evidence of ANTT/use of blood culture packs when taking blood cultures
- Cannulae in for prolonged periods of time and/or multiple cannula insertions
- Cellulitis at cannula site not identified promptly or documented appropriately
- Femoral line inserted due to poor venous access with poor documentation and delayed removal
- ANTT training below average in areas of poor compliance
- No review of Peripherally Inserted Central Catheter (PICC) in the community until 48 hours after insertion
- Delays in determining initial source of infection.
- Delays in clinical response to sepsis triggers.

6.5 Escherichia coli Blood Stream Infections

Commonly referred to as *E. coli*, this organism is part of the normal gut flora and can commonly cause urinary, biliary or gastrointestinal tract related infection leading to blood stream infections (BSI).

Despite an overall national increase in gram-negative infections, *E. coli* infections at BCUHB are decreasing. The chart below describes the total number of cases per month for the last four years from April 2018 to the end of March 2021. BCUHB reported 436 cases in 2021/22 compared to 441 in 2020/21, which demonstrates a further reduction in cases with a rate of 62 cases per 100,000 population, which is below the Public Health Wales trajectory of 67.



The majority of *E. coli* blood stream infections are from samples collected in the Emergency Department, deemed community onset with many endogenous in nature and unavoidable. A peak in cases in the summer months is also common, possibly related to complications associated with patient dehydration during the warmer weather. All cases are subject to a review and for those deemed as community or hospital onset and healthcare associated; these have been found to be largely associated with catheter associated urinary tract infection (CAUTI), often involving patients who are non-compliant with catheter management. A CAUTI project group was convened early in 2021 and has delivered a number of resources aimed at reducing CAUTI and subsequently bloodstream infections across the Health Board. These resources include a catheter passport, a catheter information card, flowcharts to include 'Trial With-out Catheter', removal and blocked catheters and a compliance audit tool. The implementation of an updated 'intentional rounding' tool incorporating nationally recognised 'HOUDINI' principles to enable staff to recognise indications for continued urinary catheter use, has been finalised and is to be rolled out in 2022.

Of the healthcare associated cases and those deemed to be avoidable, lessons learned from the PIRs include:

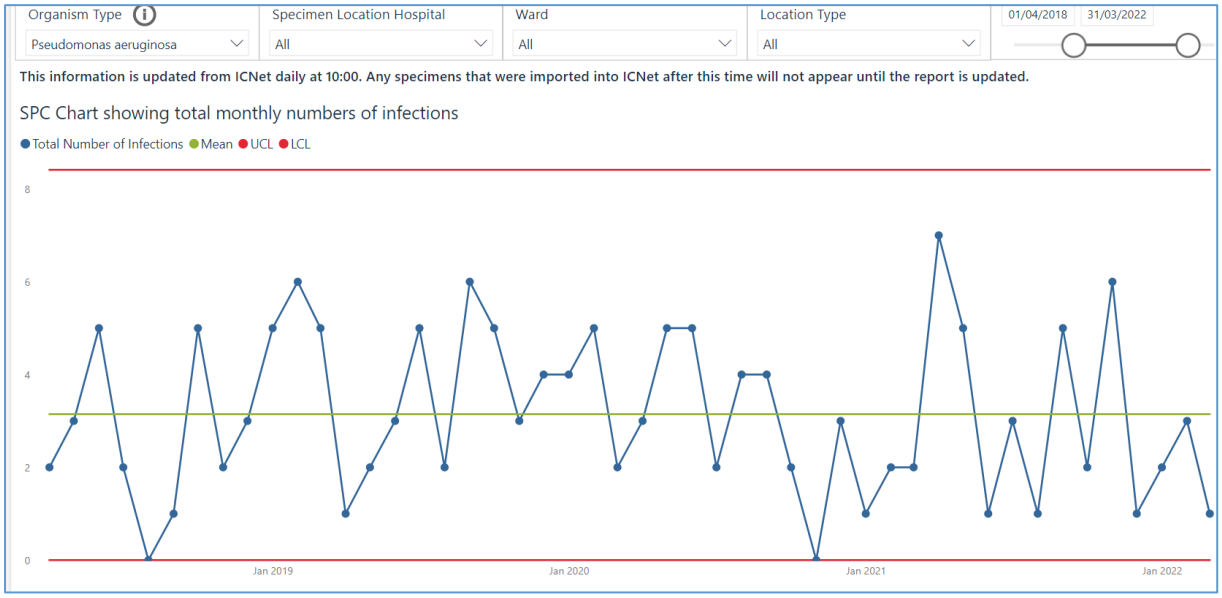
- Delayed access to urology services
- Antibiotics prescribed against guidance or as per microbiology advice
- Full antibiotic sensitivities not released so inappropriate treatment continued for five days
- Prophylaxis not given when required
- Delayed review of results leading to delayed treatment

- Lack of evidence to suggest that blood culture packs have been used and that ANTT has been performed
- Catheter insertion documentation not always completed and pathway not consistently maintained
- No rationale documented for insertion of catheter
- Urinary catheter not changed when it should be
- No documented evidence of urinary catheter bag changes

6.6 Pseudomonas aeruginosa Blood Stream Infections

Pseudomonas aeruginosa (*P. aeruginosa*) is a type of bacterium that can cause infections in humans, and is commonly found in soil, water, and plants. It is often referred to as an 'opportunistic pathogen', a bacterium that can colonise humans without causing harm, but may also cause infection and illness if a person's immune system is weakened. Water is well recognised as a source of *P. aeruginosa* and several outbreaks have been linked to contaminated water systems in hospitals.

The chart below shows total cases per month for the last four years from April 2018 to the end of March 2021. There were 138 cases in 2021/22 compared to 129 in 2020/21 but overall number of cases have remained similar in the last 4 years.



Of the healthcare associated cases and those deemed to be avoidable, lessons learned from the PIRs include:

- Full sepsis screen not always completed
- Little evidence to suggest ANTT has been performed during blood culture collection and sticker not placed in patients notes. Unable to determine who collected blood cultures
- Device related pressure ulcer

6.7 *Klebsiella* Blood Stream Infections (BSI)

Klebsiella species are a type of bacteria that are found everywhere in the environment and also in the human gut, where they do not usually cause disease. These bacteria when they multiply too much can cause pneumonia, bloodstream, wound and surgical site infections and can be associated with invasive procedures such as venous cannulation or urinary catheterisation.

The chart below shows total cases per month for the last four years from April 2018 to the end of March 2021. There were 37 cases in 2021/22 compared to 33 in 2020/21.

Of the healthcare associated cases and those deemed to be avoidable, lessons learned from the PIRs include:

- Full sepsis screen not always completed
- Poor compliance with peripheral catheter care bundles and gaps in Visual Infusion Phlebitis (VIP) score
- Urinary catheter bundles not completed in Emergency Departments

7.0 COVID-19

It has been over two years since the WHO declared a global COVID-19 pandemic but COVID-19 workstreams continued to dominate the work of the infection prevention team in 2021/22. National and Welsh guidance was regularly updated with a key change in November 2021 when there was removal of COVID-specific pathways and focusing more on the management of patients with symptoms of seasonal respiratory infections, not just COVID-19. Policies and protocols had to be repeatedly changed and disseminated at pace in line with the changing guidance.

Inpatient testing regimes were enhanced in Quarter 3 to help identify asymptomatic carriers early and the Infection Prevention Team provided clinical staff with clear guidance to highlight priorities for siderooms and support decision making for patient transfers.

With the onset of the variant Omicron, BCUHB entered another wave of the pandemic over the winter months, which again led to a significant number of staff absence either with COVID-19 or isolating as household contacts. Challenges in the isolation of COVID-19 positive patients in a timely manner before they had infected others were experienced, especially as the majority of the vaccinated patients with Omicron were asymptomatic. Omicron appears to cause less severe disease than previous variants and is more transmissible, leading to high infection rates but a reduced risk of hospitalisation.

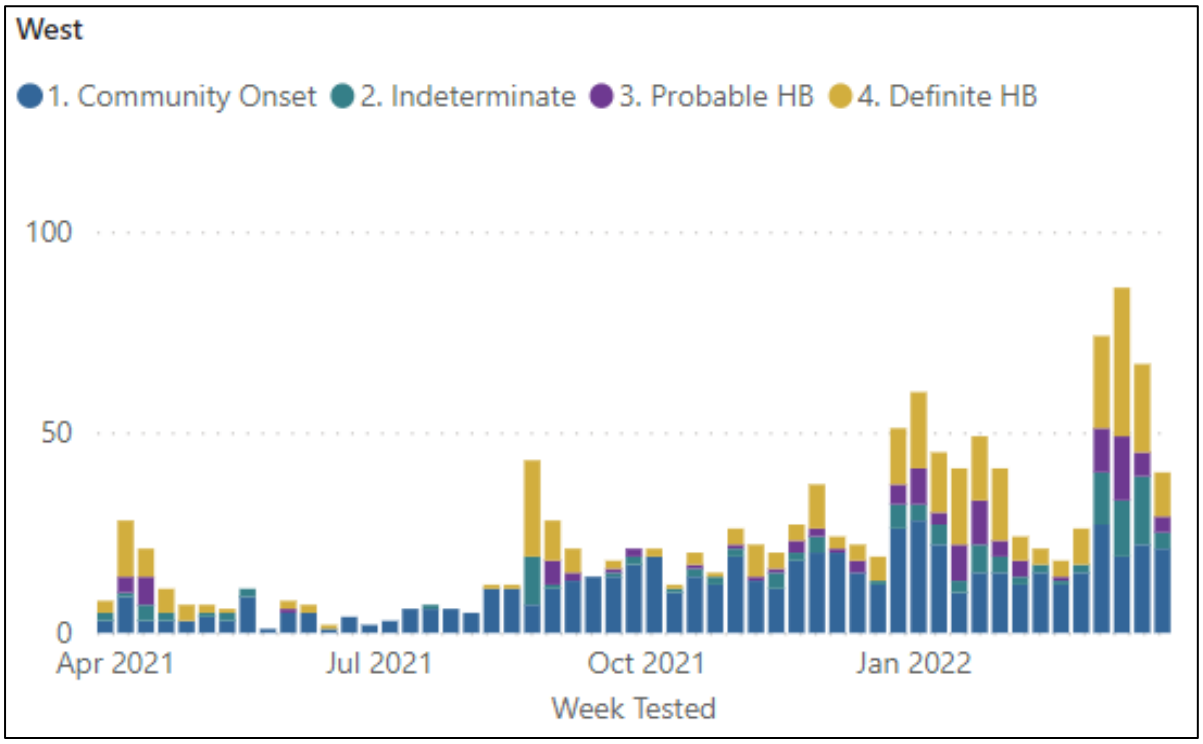
From1st April 2021 to 31st March 2022 there were approximately 2,784 patients in hospital in BCUHB with COVID-19. Of these, 1,767 were community onset, 251 Indeterminate, 190 Probable and 574 Definite following the definitions from the Welsh Government.

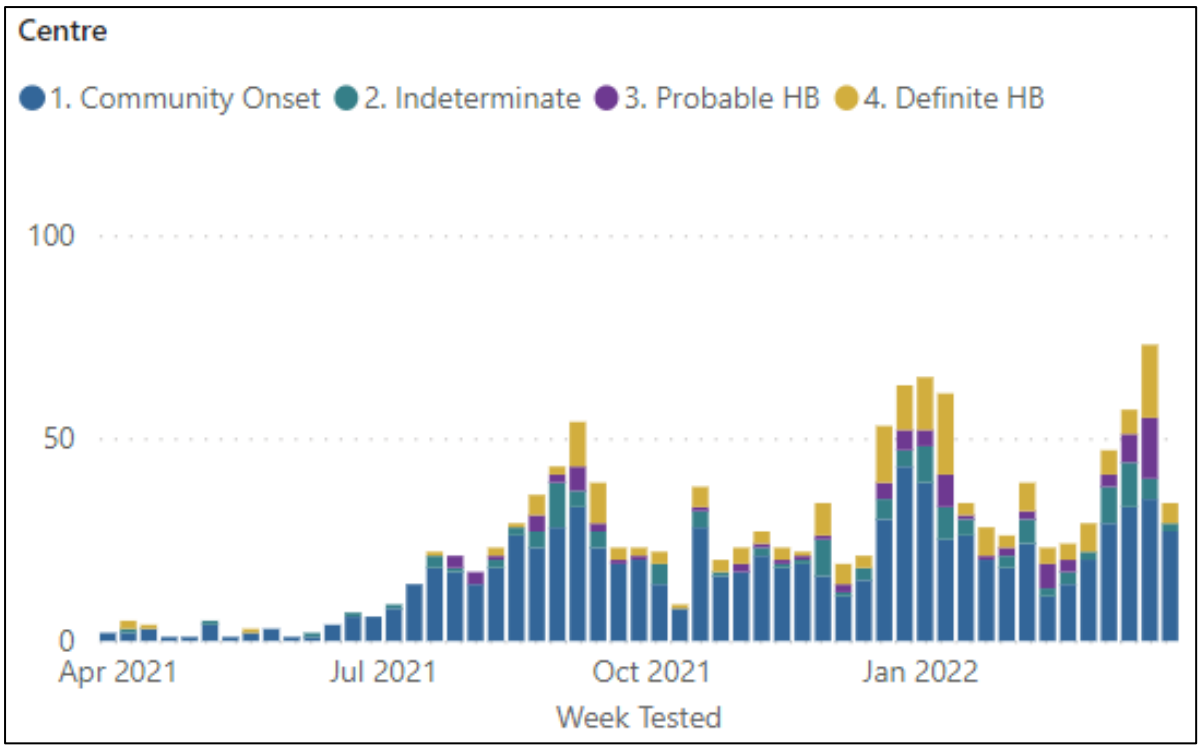
- **Community-associated COVID-19 (CA-COVID-19)** Symptoms present on admission or with onset on day 1 or 2 after admission. (Symptom onset on days 3-7 and a strong suspicion of community transmission).

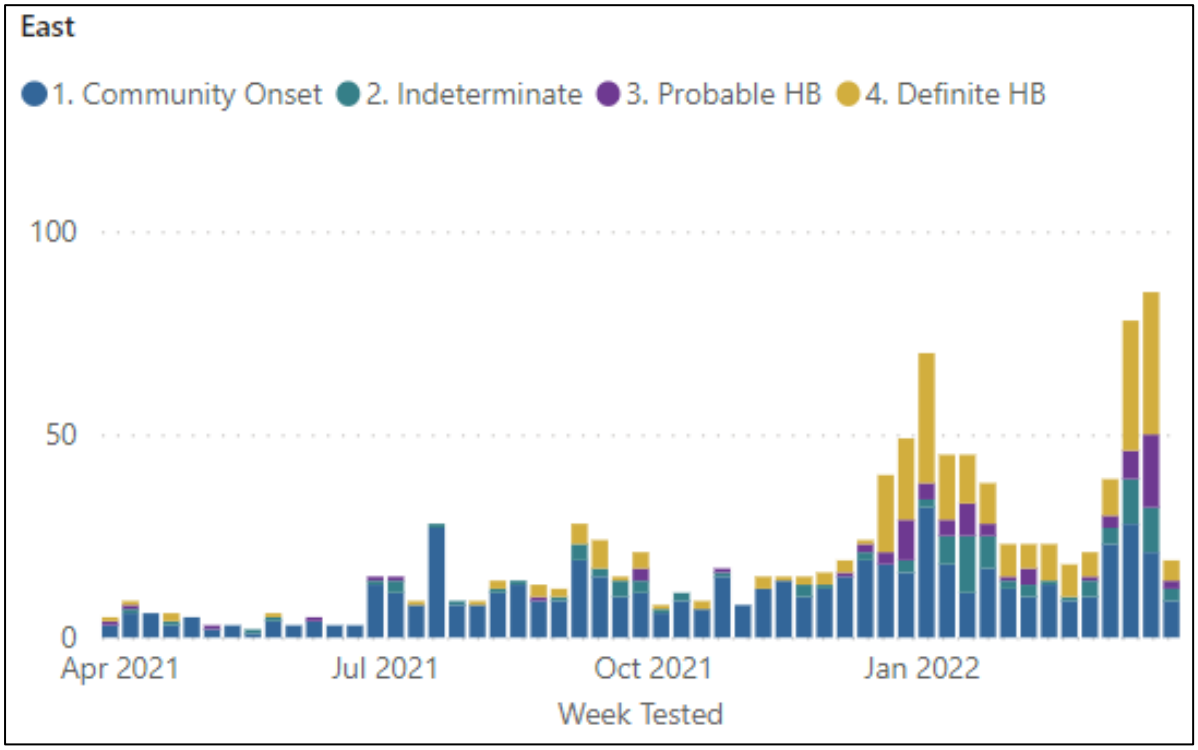
- **Indeterminate association (IA-COVID-19):** Symptom onset on day 3-7 after admission, with insufficient information on the source of infection to assign to another category.
- **Probable healthcare-associated COVID-19 (HA-COVID-19):** Symptoms onset on day 8-14 after admission (Symptom onset on day 3-7 and a strong suspicion of healthcare transmission).
- **Definite HA-COVID-19:** Symptom onset on day >14 after admission

7.1 Admission Data

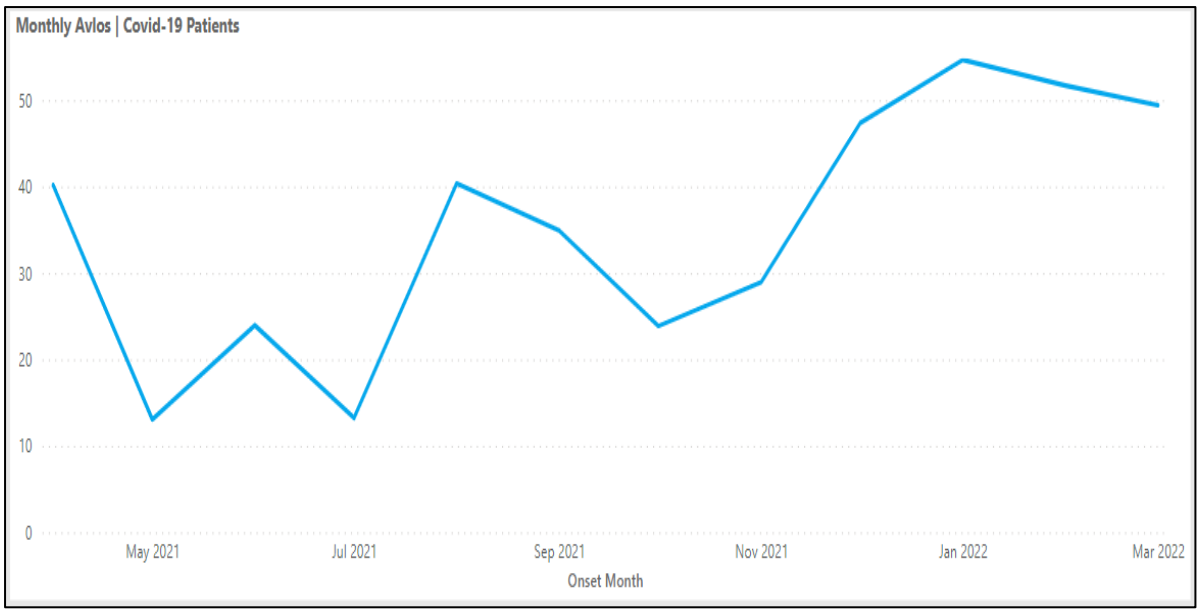
Admissions by Healthcare Acquired Infection Status are shown below for each site:







Average length of stay (April 2021 – March 2022) for these patients between April 2021 and March 2022 was 42 days and is illustrated below:

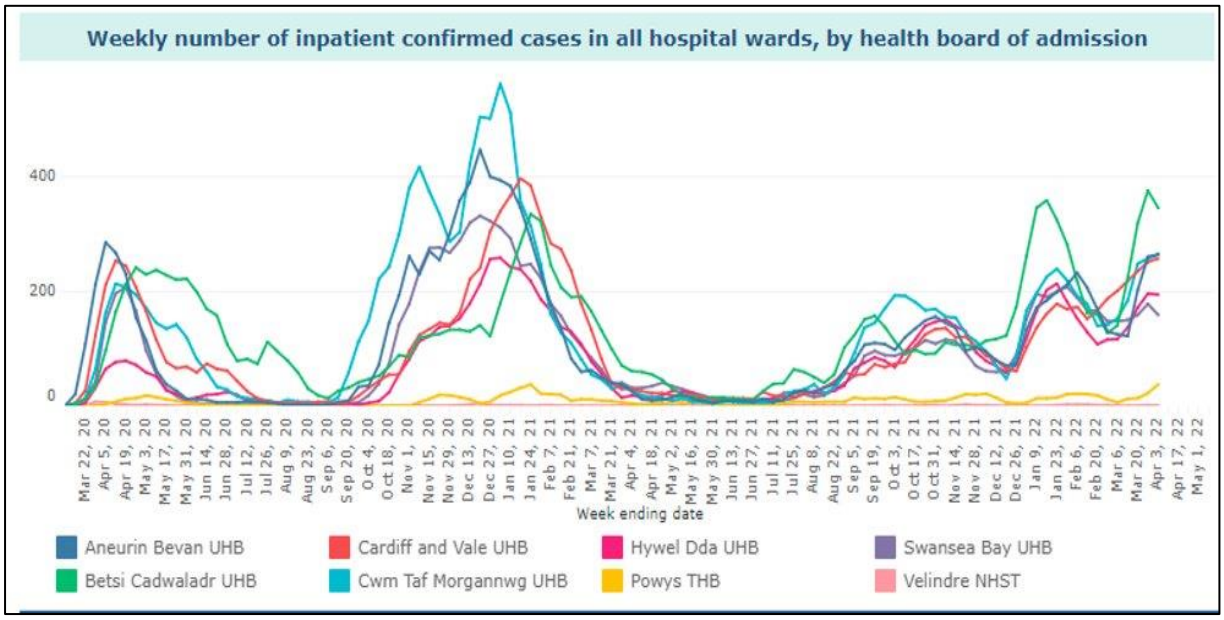


Data Definitions relating to the four graphs above

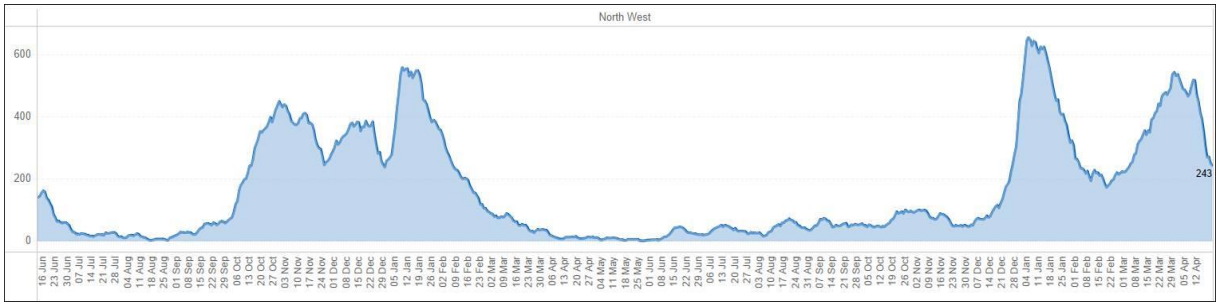
Inpatient activity is calculated based on health board spells, an individual is counted once where they were transferred between sites within a 12-hour period; transfers outside this window are counted as a separate admission/readmission. Admissions exclude the following specialty groups: Women's Services, Paediatrics, and Mental Health.

COVID-19 status is defined by a positive test result following admission or in the two days prior. Please note, test status were confounded by changes in testing policy during the pandemic. This methodology will also include patients who are not admitted for COVID-19 treatment but have a positive test result. Healthcare acquired infection status is reported based on the day's difference between admission and test dates and this may vary from the outcome following post infection review. Critical care bed day analysis was based on ward specific data therefore excludes surge beds outside these areas.

The graph below outlines the weekly number of inpatient cases in all hospital wards by health board, highlighting the high numbers seen in BCUHB compared to others, in September, over the New Year and again in late March.

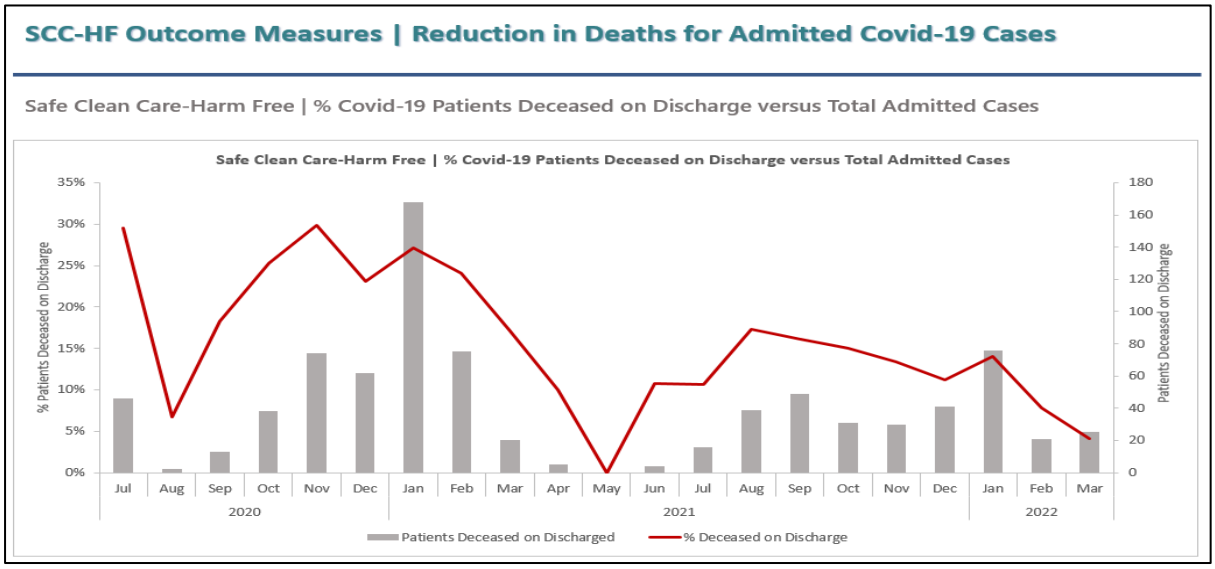


Total numbers of COVID-19 cases in the Northwest of England is illustrated below for comparison:



7.2 Deceased on discharge data

As of March 2022 month end, the % of admitted COVID-19 cases where patients were deceased on discharge was 11% for 2021-22 to date. This position is improved compared to the 2020-21 rate of 25% (July to March inclusive). COVID-19 mortality has generally decreased since the start of the pandemic, due to increased protection from vaccination, natural protection following infection and improved COVID-19 hospital treatment.



7.3 COVID-19 Outbreaks

A significant level 3 outbreak in Ysbyty Gwynedd/West occurred during February to May 2021 affecting 11 wards at the acute site, 1 ward at Ysbyty Alltwen and 1 ward at Ysbyty Eryri. A total of 128 definite or probable COVID-19 cases and 37 indeterminate cases amongst patients, and 61 staff were linked to the outbreak. An external review was commissioned by the Health Board and all learning addressed through a comprehensive action plan.

The review was completed in September 2021 and several areas of good practice were highlighted including:

- Good compliance with personal protective equipment (PPE), hand hygiene and social distancing.
- Clear pathways on entry into the Emergency Department.
- Staff were knowledgeable on infection prevention requirements
- Good communication between the Infection Prevention Team and Site Management Team.
- Good access to hand gel facilities and decontamination stations.

Recommendations identified have since been actioned via the Safe Clean Care Programme; these included:

- Improved signage in all clinical and non-clinical areas.

- Installation of new Patients Own Drugs (PODs) to keep patients separated.
- Programme of installation of doors on patient bays in the wards.
- Clear segregation of patients on different pathways.
- Protocol to support staff with decision making regarding the above.
- All staff rooms, offices and other shared areas having clear signage for the maximum number of individuals.

A number of smaller outbreaks that were generally contained more quickly occurred from May-November until the emergence of the more infectious Omicron variant occurred in December 2021. January 2022 saw all three sites/areas affected by COVID-19 outbreaks with all three sites in level 3 outbreak by the end of March 2022. A pan BCUHB outbreak meeting was initiated, chaired by the Executive Director of Nursing and attended by representatives from Public Health Wales and a Consultant Nurse from the HARP team. The Consultant Nurse, following attendance at three of these meetings provided feedback to the Health Board that she was assured that there were clear controls and actions in place, with 'excellent communication/working between the Infection Prevention team and the three areas of the Health Board' and that 'the data and analysis presented by the regional teams had been very comprehensive in describing the situation in point of time alongside the current risks and threats'. She also reported that she had been impressed by the additional data collected in understanding harm are excellent for example vaccination status, respiratory severity and staff movement data.

For each case of healthcare associated COVID-19 cases, a detailed patient incident review was completed, with a significant number of these and associated outbreaks undergoing scrutiny by a panel led by the Deputy Director of Nursing. Key themes identified included:

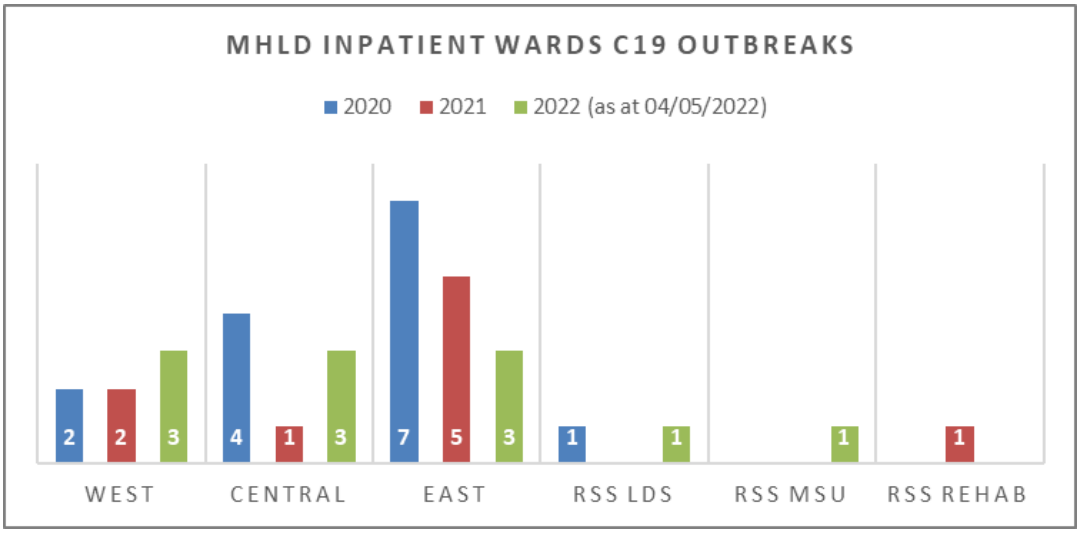
- staff movements within areas of work
- patient movement and transfers
- care of wandering patients
- staff behaviours in communal areas
- inconsistent reporting and investigating
- data systems not always aligned and inconsistent communications.

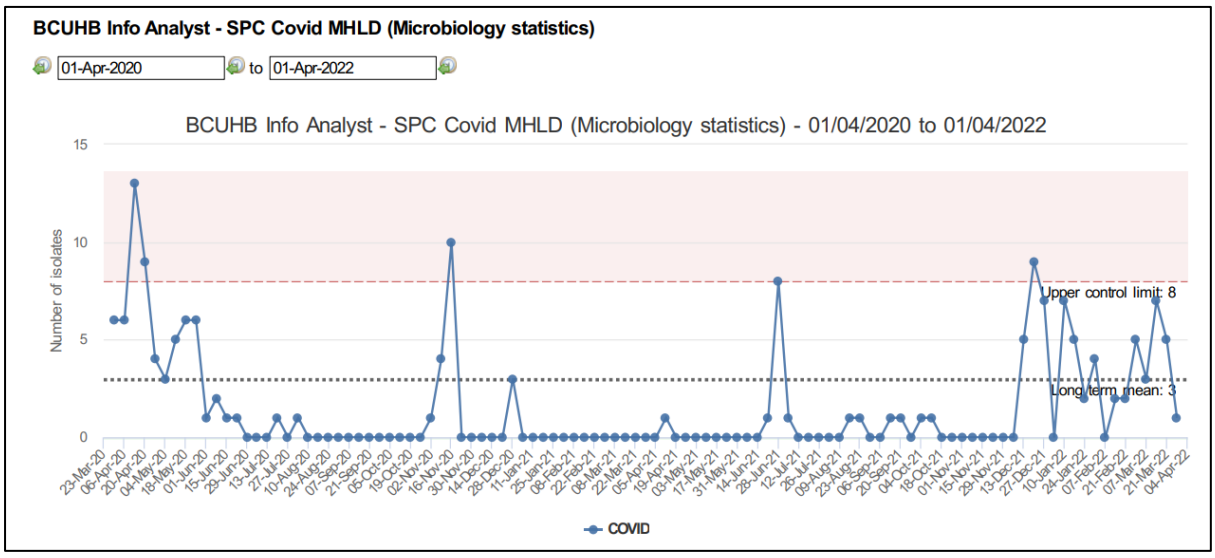
Key actions to prevent reoccurrence included:

- revised policies and procedures
- minimising staff and patient movements
- additional staff provision to support wandering patients
- enhanced social distancing measures in communal areas
- detailed COVID-19 outbreak procedures
- increase in the frequency of swabbing patients
- increase in the number of siderooms to isolate patients
- improvements in data systems and the use of data at meetings.

As a result, outbreaks were in general were identified, and contained more quickly, with prompt action to ensure ongoing transmission and outbreak reduction.

No COVID-19 outbreaks have been reported within Women's Health, however, the Division of Mental Health and Learning Disabilities have had 34 outbreaks of COVID-19 since the pandemic commenced in 2020, with cases peaking again in quarter 4 in line with the higher community transmission rates. East had the highest number of outbreaks, as illustrated below.





Themes for improvement from patient incident reviews related to staff being unfamiliar with the latest change in guidelines, patients and staff not adhering to PPE advice and cleaning issues. The Division have reviewed and refined how they record and document patient infections and clarified the process to ensure learning is disseminated across the organisation.

Care Homes

The North Wales response to preventing, containing and managing the spread of COVID-19 in care homes and other closed care settings was, and continues to be, multi-agency and multi-disciplinary. Throughout the pandemic BCUHB have been able to demonstrate how lessons learnt informed support to the sector in relation to infection prevention and control.

The care home Multi-Agency Oversight Group (MAOG) was established and met daily. The group had access to the Infection Prevention and Control team, Public Health, Health Protection and Environmental Health Officers advice and support to the sector for both prevention and incident management. The MAOG brought experts together quickly to understand the scale of outbreak and actions to contain spread. This team provided rapid insight to the pattern of infection. Some of the key achievements included:

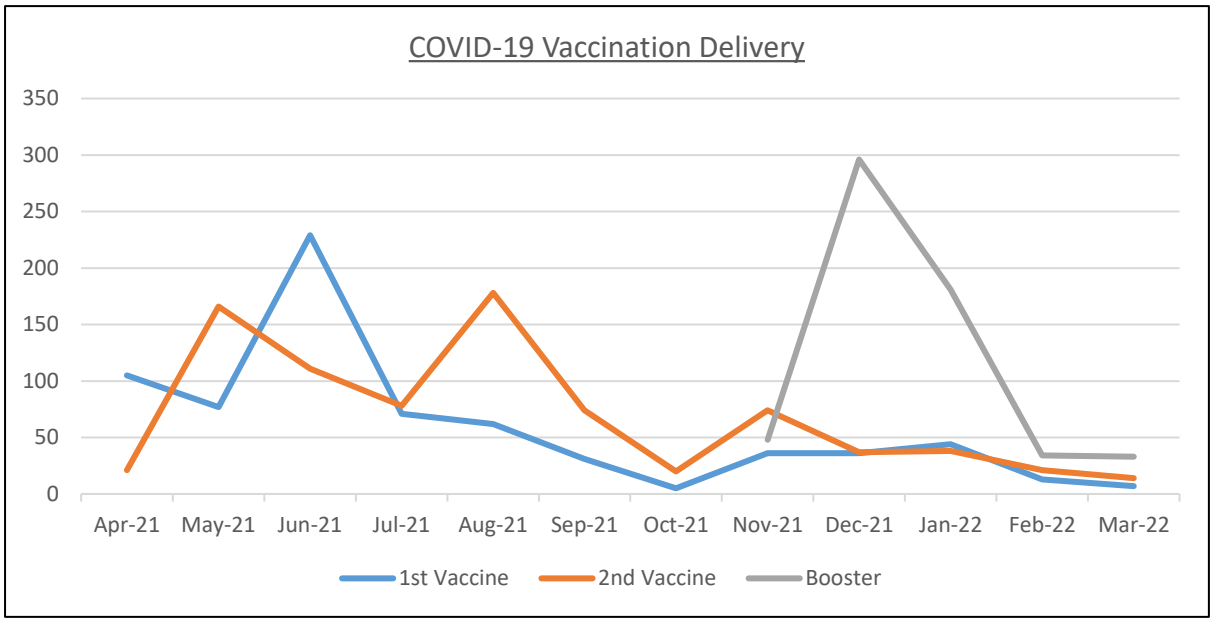
- Development and implementation of 'Infection Prevention Packs' for care homes including quality tools for both proactive and reactive control and management.

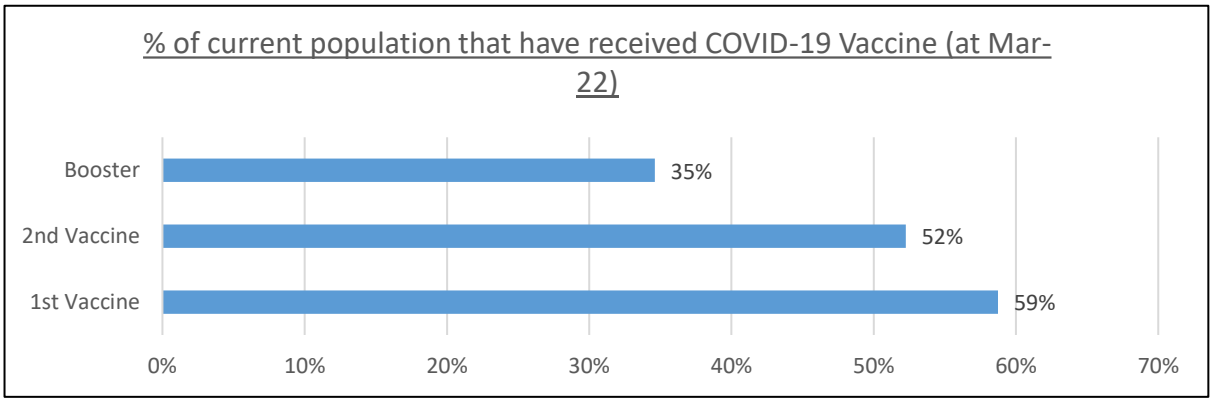
- The co-ordinated response for infection prevention and control advice and support was strengthened (specialist Infection Prevention and Control, Quality Care home teams, Environmental Health Officers) with both on-site and virtual visits.
- A triage system was established with the MAOG to take referrals from Environmental Health Officers with daily triage to identify if a physical or virtual visit was required. Infection prevention visits were made by Practice Development Nurses and Specialist Infection Prevention staff. From 29 December 2021 to 27 January 2022, 30 Infection Prevention team visits were supported by proactive phone calls and regular Teams meetings.
- A protocol was developed for the discharge of patients from hospital.
- The system for accessing vaccinations for staff and residents in care homes was much improved for the booster programme, with good update and minimal delays experienced.

COVID-19 in HMP Berwyn

Vaccination data:

Despite an active campaign, vaccination levels were lower at HMP Berwyn compared to the general population as illustrated below.





There is a PHW proposal to investigate vaccine hesitancy in prisons across Wales this year, in partnership with HMPPS in Wales and the PHW Vaccine Preventable Disease Programme. Further knowledge can be used to develop interventions to improve vaccination uptake amongst this population and support the Welsh Government 'COVID-19 Vaccine Strategy for 2022'[1] which focuses on vaccinating the most vulnerable and nobody left behind.

COVID-19 cases:
2525 new arrivals at HMP Berwyn received PCR Tests between Apr-21 and Mar-22 with 59 positive results (2%).
648 men were isolated due to being symptomatic or sharing a room with someone symptomatic between Apr-21 and Mar-22.
A COVID-19 Outbreak was declared on 10 December 2021. Regular outbreak meetings were held Chaired by Dr Richard Firth, Consultant in Health Protection with Public Health Wales. Members of the Infection Prevention Team attended each meeting to provide advice and support. On 5th April 2022 numbers of COVID positive staff were continuing to reduce and it was agreed they could move back to stage 1 precautions only.

7.4 Investigation into Nosocomial Transmission of COVID 19

Employees at BCUHB have worked incredibly hard throughout the COVID-19 pandemic to minimise COVID-19 outbreaks in hospitals, protecting patients, carers and families, often in very difficult circumstances. However, despite the procedures, guidance and checks in place, COVID-19 infections have been contracted in hospitals and in some cases; some people may have come to harm or died after acquiring COVID-19 in hospitals.

On the 25 January 2021, the Quality & Safety Team at the NHS Wales Delivery Unit (DU) were commissioned by the Welsh Government to develop a National Framework to support a consistent national approach towards investigations following patient safety incidents of nosocomial COVID-19.
In March 2021, the Framework into the 'Management of patient safety incidents following nosocomial transmission of COVID-19' was published and work proceeded to recruit a small team to review and extrapolate data to ascertain the number of infections at BCUHB. A directive by the Deputy Chief Executive/Executive Director of Nursing and Midwifery was pursued to contact identified COVID-19 HCAI patients in relation to an outbreak in Wrexham Maelor Hospital and Glan Clwyd Hospital in July 2020. A total number of 167 patients received correspondence from BCUHB in September 2020 and November 2020. A further holding letter was submitted to the families in December 2020 and February 2021. Communication has continued with patients and families providing a clear indication of our intentions to review and investigate whether harm was caused by the Health Board with reference to breach of duty or Qualifying Liability.

A COVID-19 Project Manager was appointed, working within the Patient and Carer Experience Team, alongside a part time Complaints Manager and an administrator on secondment from the Complaints Team. Good working relationships and communication with Welsh Government, NHS Wales Shared Services Partnership, Public Health Wales, Legal and Risk services, Coronial services and the Medical Examiner and Infection Prevention and control team were established. A list of COVID-19 healthcare associated infections (HCAI) was identified with collaborative joint working with the local epidemiologist, Public Health Wales and the Infection Prevention and Control team for data validation. All HCAI COVID-19 complaints were captured via the current complaints handling process with a formation of clinical panels established to review. Part time investigators were recruited in September 2021 to pursue with the investigations with the patient, families and carers prime in steering the

[1] covid-19-vaccination-strategy-for-2022_0.pdf (gov.wales)

project. Progress has been made, however a significant increase in resource is required to support continued work and the increased number of infections.

Following the announcement in January 2022 that the Welsh Government will provide funding to the Health Board dedicated to the Health Care Acquired COVID-19 Reviews (£878,000 per annum for two years), the team will pursue with the appointment of a dedicated resource with clear objectives and effective leadership. The proposed team will consist of a Complaints Lead Manager, Clinical Lead, Clinical Investigator, Project Manager, Complaints Manager, Clinical Auditor, Patient Advice Liaison Officer, Investigators and Administrators.
Pro-active engagement from the outset in real time with excellent communication facilities for patients, carers and families to access will be fundamental and a dedicated single point of contact will be implemented with additional supporting avenues. This will provide a high level of assurance that all patient safety incidents within the acute and community sites as well as NHS funded Care homes and beyond will be included. Clarification is due imminently on the criteria for the investigations in to NHS funded placements within care homes, this will include supported living accommodation where patients are receiving CHC funded care. All Investigations will abide by the framework and lessons learnt shared with all disciplines to improve patient safety.

The Health Board are in continuous contact with the DU and neighbouring Health Boards, and similar to the Kings Lynn Trust, the Health Board have adopted a proactive approach to engage with the families of those affected with the nosocomial transmission of COVID-19 to include them as part of the proportionate investigations. The Health Board will encourage meeting families in person to explain, but more so to let them "tell their story". The feedback to date has highlighted the importance of being able to discuss openly in their language of choice i.e. Welsh/English. The Health Board will also encourage staff involved in the patients care to participate in the conversations with families and support staff to understand what patients and families were going through at the time.
The Health Board is implementing an adjudication panel to provide assurance when reviewing the level of harm.

At the time of writing, the number of cases currently investigated is 255.
The re-occurring themes from the investigations to date include:

- It is not often possible to close contact bay doors as patients are at high risk of falls.
- Inadequate ventilation on the wards.
- Patients not wearing face masks.
- Social distancing not adhered to in communal areas and during staff breaks.
- Wandering patients on the wards not abiding by social distancing and mask wearing.
- Patients leaving wards to smoke, increasing the risk of transmission.
- Full establishment of staff unavailable on the wards due to sickness/COVID-19 absence.

Examples of Good Practice include:

- Excellent communication documented by Doctors, when discussing with families the patients condition, deterioration and their options to visit at end of life care.
- Hand hygiene scores remained consistently good.
- Printed names, designation and signature on the 'Nursing Admission Document' for patient care.
- Practitioners such as Physiotherapists and Occupational Therapist empathic with their patients and robust with their documentation and follow on care.
- The use of stamps on documentation which have Nurse/Doctors name and their PIN number.

- Some evidence of good standards of record keeping in the Nursing/Doctors notes.
- Patient record when transferring from care homes to hospitals are well documented, this includes the 'This is me RCN' which includes detail supporting transfer of care.
- Provision of changing facilities to ensure that staff change into and out of their uniform on site

Learning is extracted from investigations and information presented in a timely manner as an action/improvement plan in preparation for any future waves, currently by way of circulating information with infection prevention and control colleagues via the Safe Clean Care - Harm Free work stream.
The Project team are currently working on a plan to engage and communicate with real time patients who have acquired COVID-19 in the hospital, to offer support and improve patient experience. Staff will dedicate time in effectively signposting them to Long COVID-19 clinics, seeking relevant support services and supporting with bereavements in addition to any additional support they may acquire.
The Project team implement a single point of contact managed five days a week (Monday to Friday) for patients, carers and families affected by health care acquired COVID-19. The service will utilise support from the communications department to promote the service.

7.5 Personal Protection Equipment Steering Group

In 2021/22, the Personal Protective Equipment (PPE) Steering Group continued to provide clear oversight and active management of key actions with a focus on patient, public and staff safety, adequate PPE supply, risk assessment and staff training. Members of the Steering Meeting undertook an active role in presenting positive proposals with excellent attendance at meetings and a positive contribution from staff side colleagues. Meetings were held more frequently during the COVID-19 peaks and the group reported directly to BCUHB COVID-19 Silver Command.

Communications to staff, patients and visitors relating to PPE has been dynamically managed, with prompt responses to changes in National Infection Control Standards. The Steering Group received excellent support from the BCUHB Communications Team providing regular PPE briefings in the form of staff bulletins, social media posts, updates to the website COVID-19 hub and media statements. Infection Prevention representation at the meeting ensured PPE information was shared promptly with staff and patients and reviewed for assurance to meet the necessary IPC National standards prior to release.

The Health Board faced complex challenges of logistics and operations surrounding PPE supply, which was challenging given size of the operational footprint. However, with the introduction of demand management profiling and stock control assessment, working closely with procurement and operational hubs, this provided the necessary assurance required. The Steering Group was presented with rich data to ensure the Health Board recognised its forecasting and demand for products, in particular FFP3 masks, to ensure they could meet the needs of staff.

Health and Safety colleagues worked closely with the Steering Group and were supported by Professor Rees, to ensure they kept up with latest medical and scientific advice to inform and refine risk assessments and operational protocols utilising the Hierarchy of Controls. They also delivered the FIT Testing Programme and ensured that the Health board was sighted on

the most current national guidance relating to PPE and HSE legal requirements. This was implemented and compliance closely monitored.

7.6 Test, Trace and Protect (TTP)

Welsh Government adopted population-wide contact tracing as part of TTP on 1 June 2020. It has played a crucial part in the Welsh Government's (WG) response to the COVID-19 pandemic, operated in partnership by Public Health Wales (PHW), local authorities, Health Boards and wider partners. The structure of TTP in Wales has been commended by the Welsh Government Ministers and Senior Officials as a real strength of the programme.

The TTP Strategy aims is to enhance health surveillance in the community, undertake effective and extensive contact tracing, and support people to self-isolate where required to do so. This involves advising people to report symptoms, test those who are showing symptoms of COVID-19, and tracing those they have come into close contact with.

Testing

Following its rapid evolution the Antigen Service consolidated in 2021/22, the service continued to work in partnership with Local Authorities and UK DHSC to proactively manage the deployment of Mobile Testing Units supplementing the two Regional and four Local Testing Sites. The service also piloted the deployment of Mobile Processing Units alongside two of the sites, which allowed members of the public to receive their results within one hour of their swab. All of these facilities were withdrawn at the end of March 2022 as the Government's public testing strategy changed.

The four BCU-managed Community Testing Units, at Alltwen, Parc Menai, Glan Clwyd and Wrexham Maelor continue to operate to test symptomatic Health and Social Care staff and care home residents, outbreak testing, and a service for those patients who the criteria under the Welsh Government Patient Testing Framework. The Health Board is currently working through the revised Welsh guidance to review which form of testing is the most appropriate for each of its services, based on a risk assessment and patient's individual risks from infection and vulnerability.

The Community Testing Units currently have the capacity to undertake 2,842 COVID-19 swabs per week and have requested, within their funding allocation, additional revenue for the anticipated surge period to continue to support Care Homes and other closed setting outbreaks.

The WAST Reserve Mobile Testing Unit was deployed to communities to deliver lateral flow device (LFD) Collect and Supervised LFD when it was not responding to incidents and outbreaks.

The pilot for staff access to LFD testing was fully rolled-out by the end of June 2021 and over 15,500 patient facing staff agreed to participate in twice weekly asymptomatic testing.

Tracing

The Tracing Services across North Wales continues to be managed by the BCUHB TTP Regional Hub in partnership with the six local authorities and Public Health Wales.
Over the last 12 months the tracing service has worked effectively with internal and external partners to support outbreak management and variants of concern, trace positive cases, identify their contacts, ask them to isolate and monitor their health whilst in isolation in line with rapidly changing Welsh Government policy. During this period:

- 190,000 index cases were identified in North Wales of which 181,000 were eligible for follow-up.
- 307,000 contacts were identified of which 284,000 were eligible for follow-up.
- 4040 inpatient and 2660 BCUHB staff cases were contact traced.

In March 2022 Welsh Government published 'Together for a Safer Future: Wales Long-term COVID-19 Transition from Pandemic to Endemic' which sets out the transition plan for TTP. With the reduction in wide-scale testing the need for contact tracing will also reduce, and will focus on protecting the most vulnerable and supporting the response to local outbreaks. A new Contact Tracing service is being established to ensure that the right capacity and capability is in place to meet this changing demand but also be resilient enough to scale up to meet any potential outbreak or new variant of concern.

Protect: Community Support Hubs
The protect service is a multi-agency model with local authorities, the voluntary sector and community groups that deliver key health, social and wellbeing interventions through a number of Community Support Hubs across North Wales.
From a starting point of five hubs, 17 hubs now operate across North Wales working in partnership with over 230 partners from the public and voluntary sector using existing funding streams and only funding where a gap in service exists. To date, hubs have helped over 70,000 residents and handed out 491,000 LFD tests.

Core services include, but are not limited to:

- Lateral Flow Device (LFD) testing kit collection (in accordance with current policy)
- Food+ (either foodbank or/and cooked meals/classes)
- Accommodation/tenancy support
- Money/debt management/Credit Union/benefit advice
- Legal advice (family, employment, civil matters)
- Fuel/heating support
- Household goods (including white goods)
- Family support
- Mental & physical health support
- Sensory support
- Domestic & substance abuse support
- Gender support
- Digital inclusion
- Multi-lingual support
- Modern slavery & exploitation support
- Entry to employment/sustaining employment
- Social prescribing

The objective of the Protect Service is to work with communities to address their immediate vulnerabilities whilst supporting residents to become more resilient to long-term social and economic impacts. Residents will be supported and empowered to make positive, sustainable choices over time. There is no eligibility criteria to access the support.

8.0 Other Significant Infections

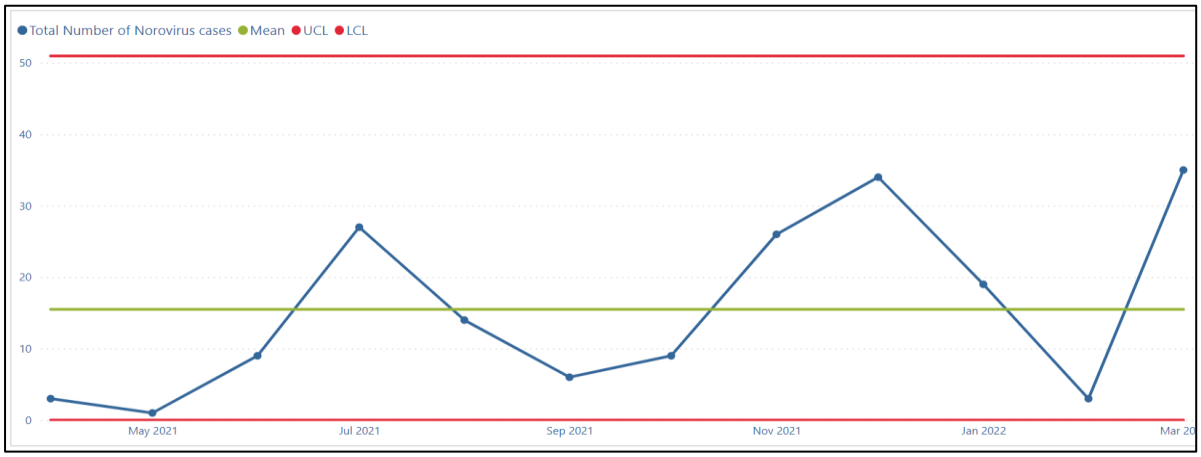
8.1 CPE (Carbapenemase-producing Enterobacterales)

Enterobacteriaceae are bacteria that usually live harmlessly in the gut of humans, however, the bacteria can occasionally cause infection in the bladder, bloodstream or wounds, requiring additional treatment with antibiotics. Carbapenemases are enzymes made by some strains of

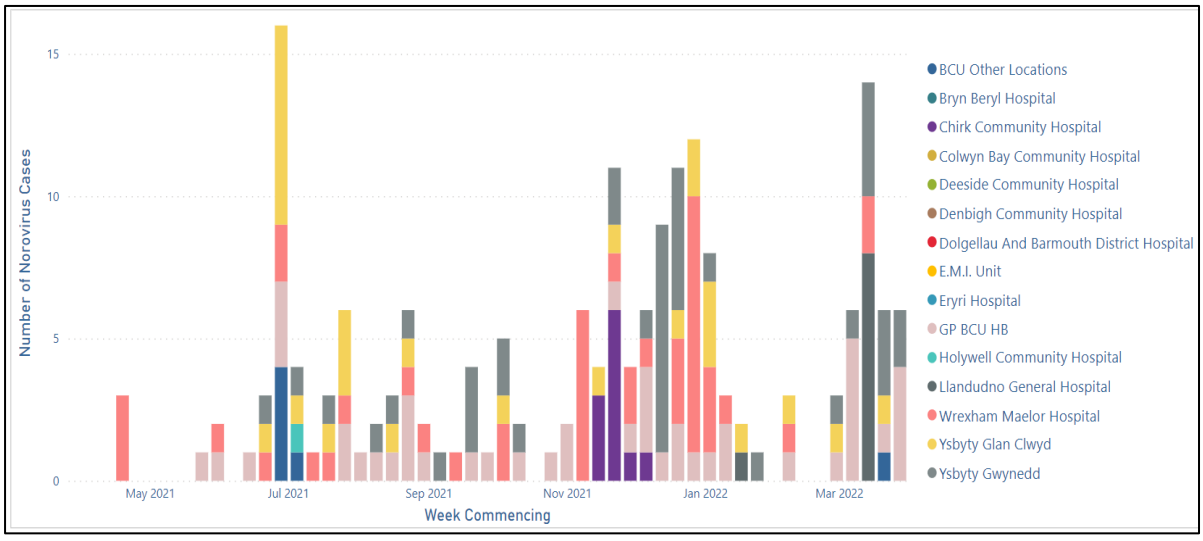
these bacteria, which allow them to destroy carbapemen antibiotics and so the bacteria are said to be resistant to the antibiotics. The increased incidence of carbapenemase-producing Enterobacterales (CPE) has significant cost and operational implications for healthcare providers.
In 2021/22 in BCU there were no cases where CPE was thought to be acquired in hospital.

8.2 Norovirus

Norovirus is a highly contagious, self-limiting viral infection causing vomiting and diarrhoea. It is easily transmitted through contact with infected individuals or contaminated surfaces, water or food.
During 2021/22, there were 186 laboratory confirmed cases of Norovirus (compared to 29 in 2020/21). Of these, 45 were from samples collected by GPs, East reported 55 cases (44 YWM, 11 community hospitals), Central reported 38 (28 YGC, 11 community hospitals) and West reported 42, all from YG. There were six reported cases from unknown locations.
The total number of laboratory confirmed cases of Norovirus during 2021/22 is illustrated in the chart below:



The total number of laboratory confirmed cases of Norovirus during 2021/22 by location is illustrated in the chart below:



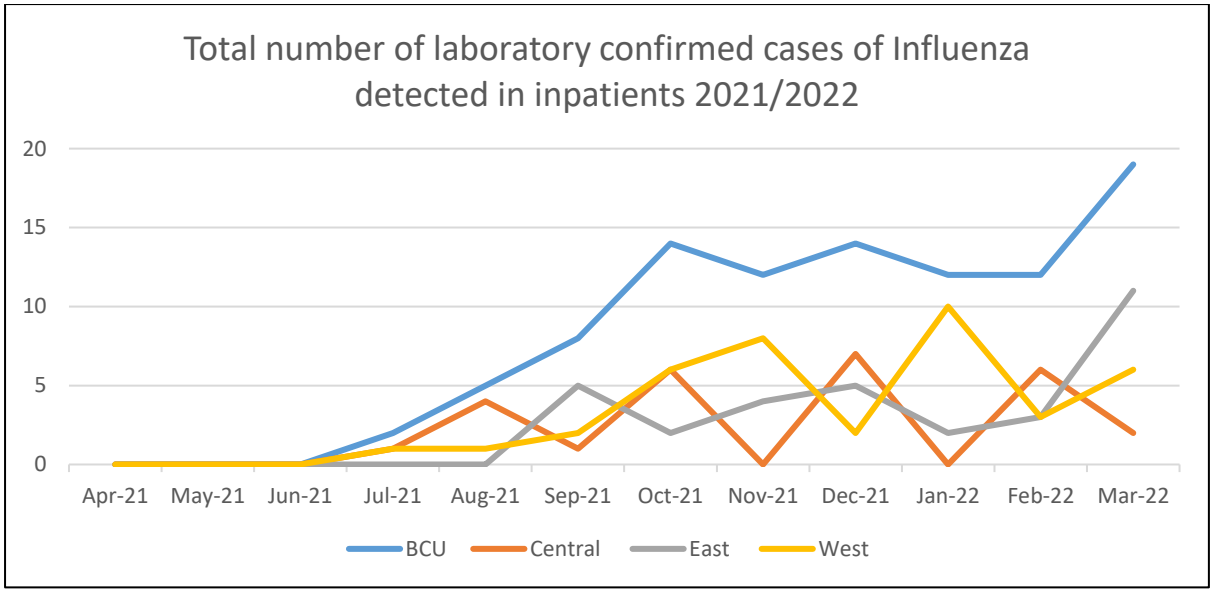
Of the 135 cases reported from samples collected in hospital, Central reported two outbreaks resulting in the closure of three wards with 13 confirmed cases. East reported seven outbreaks

with seven ward closures and 28 confirmed cases. West reported four outbreaks with four ward closures and 21 confirmed cases.
Learning outcomes form the outbreaks included:

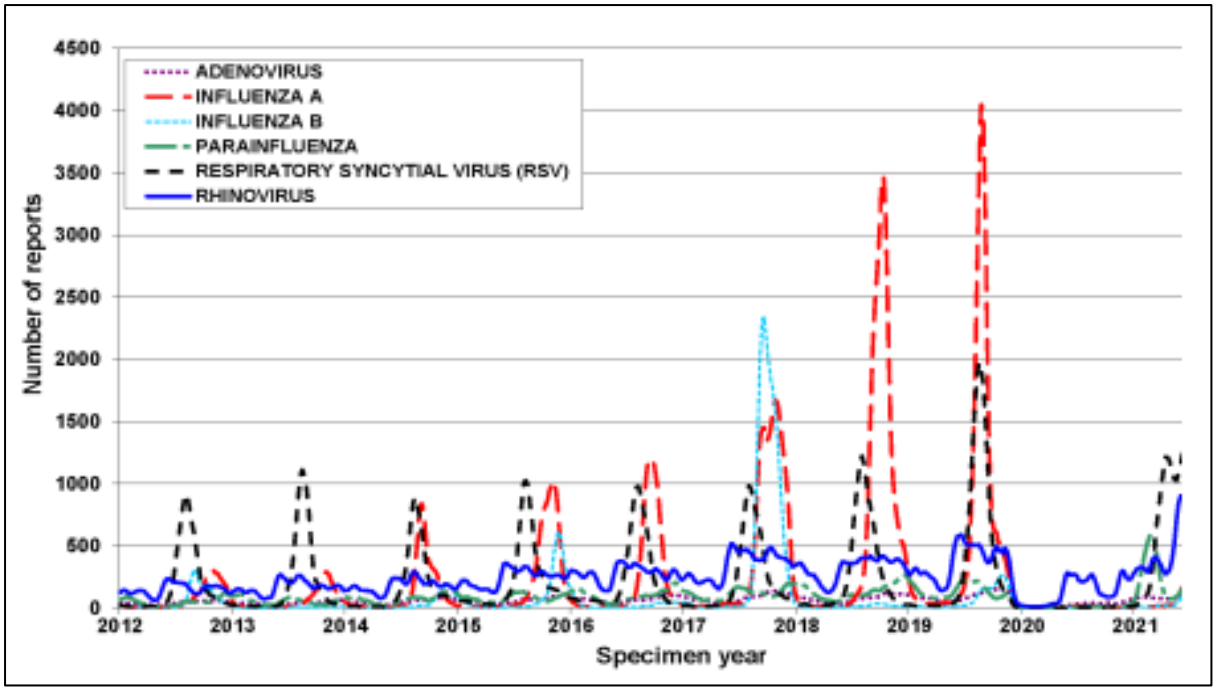
- Delays in the isolation of patients with symptoms
- Delays in sending samples.
- Delays in commencing Bristol Stool Chart or other gaps in documentation.
- Inability to close doors on bays due to other risks e.g. patients walking with purpose.

8.3 Influenza

Influenza (flu) is a highly contagious virus that causes respiratory illness that is easily spread, resulting in seasonal epidemics every year. Flu is predominantly transmitted through respiratory droplets and via contaminated surfaces, which may enter the mouth, nose or eyes (via conjunctivae).
During the 2021-22 influenza season, there were 99 laboratory confirmed cases of Influenza A across BCHUB in inpatients compared to just eight cases the previous year. However, these numbers are significantly lower than those seen pre COVID-19 pandemic.
East reported 32 cases of which sever were defined as hospital onset, Central reported 27 cases, seven of these defined as hospital onset and West reported 40 cases; 11 defied as hospital onset.
Of the 99 cases, 68 were reported in adults (>16 years of age). Despite the number of hospital onset cases there were no identified links in cases and therefore, no flu outbreaks declared in 2021/22.



The graph below presents the six major respiratory viruses reported in England and Wales (with the exception of COVID-19) between 2012 and week 16, 2022 (3-week moving average). This assists in illustrating the difference in the last two years during the COVID-19 pandemic.



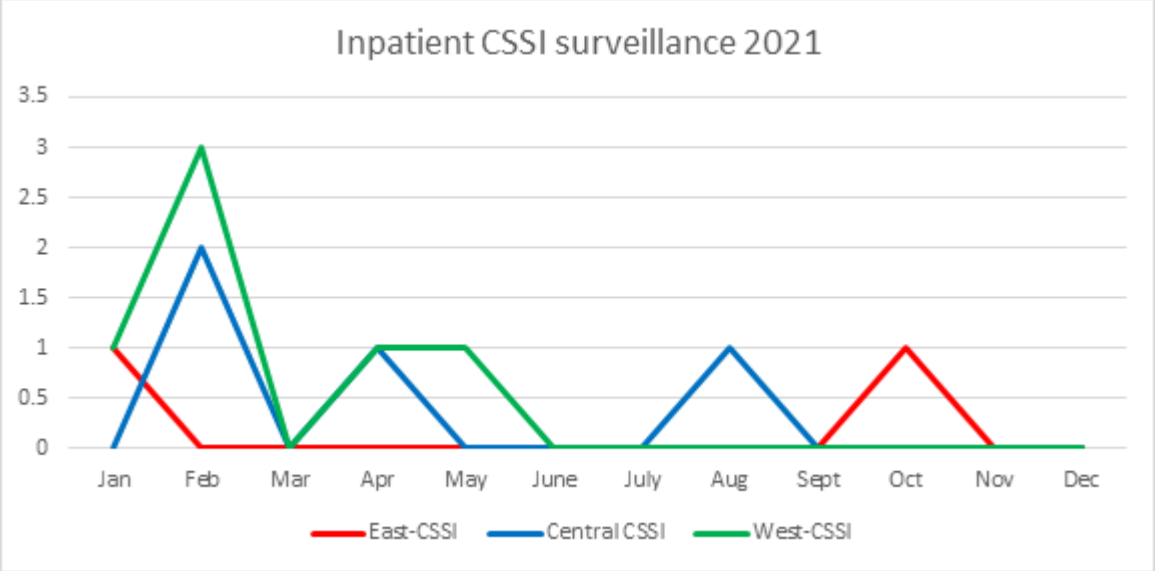
Measures to minimise COVID-19 infections have clearly had a dramatic effect on the other respiratory viruses which, unless significant restrictions on activity and behaviour are introduced again, is unlikely to reoccur next winter.

9.0 Surgical Site Infection Surveillance

9.1 Caesarean section Surgical Site Infection (CSSI) Surveillance

Since 2006, all Health Boards in Wales that undertake Caesarean sections have been required by the Welsh Government to participate in CSSI to examine infection rates associated with the procedure. Data are collected on all elective (or planned) and emergency procedures.

During 2021/22, BCUHB has seen standardisation of reporting of CSSI across the three maternity units and in conjunction with Healthcare Associated Infection and Antimicrobial Resistance Program (HARP) and the three CSSI links across North Wales data is now collated centrally as illustrated below.



The report for CSSI for 2020, published and circulated by HARP has not yet been received by the Health Board. However, collation of the data has allowed analysis without the need to wait for the HARP report, enabling closer, real-time monitoring and the ability to identify themes and trends earlier.

BCUHB inpatient rates of CSSI are extremely low, this evidences good infection prevention within the maternity theatres, however, BCUHB continues to see caesarean section wound infection in women at 8 to 14 days postnatal.

Improvements planned for 2022 include:

- A focus on prevention infection in women at 8 to 14 days postnatal: roll out wound care training to all midwives and update the current patient information leaflet and wound management pathways.
- Update dressing protocols in line with NICE recommendations: BCUHB have also agreed to the implementation of antimicrobial sutures for both uterine and skin sutures (a NICE recommendation), which will standardise practice across North Wales.

9.2 Orthopaedic Surgical Site Surveillance

Scheduled orthopaedic surgery was reduced in 2021/22 due to COVID-19 pressures. Any infections that surgeons are notified of are discussed at monthly multi-disciplinary meetings with Microbiology and learning identified and acted on. Data is also submitted to Public Health Wales but comparative orthopaedic SSI data for has not been provided for the last couple of years, as several Health Boards have not submitted complete datasets. PHW are looking to make this surveillance programme voluntary in future and there is a meeting in Cardiff in September 2022 to discuss this further.

10. Vaccination programmes delivered in BCUHB

10.1 COVID-19 Vaccination

The COVID-19 vaccination programme in North Wales was launched in December 2020. Completion of the first phase occurred by 31st August 2021, followed by an autumn 'Booster' Programme. Spring delivery as per Joint Committee on Vaccination and Immunisation (JCVI) National Guidance commenced in March 2022.

Current Position

Total Vaccinations	1st Doses	2nd Doses	3rd Primary Doses	Booster Doses	Healthy 5-11s	12-15s	16-17s
1,573,748	584,571	541,555	19,747	427,875	1704	29,414	20,081

Data Correct as of 11.04.22

During autumn 2021, the 'Booster' phase of the programme commenced, which saw the introduction of the Moderna vaccine, which added flexibility to the programme.
December 2021 saw the delivery of the programme at a rapid speed in response to a UK wide surge delivery, due to the 'Omicron' variant. Week commencing 13th December 2021 saw a record 113,000 vaccines administered, in response to staff re-deployment and a colossal effort by all involved.

Many of the oldest adults and therefore most vulnerable, received their most recent vaccine dose in September or October 2021. As these individuals are at higher risk of severe COVID-19, it is possible that their immunity derived from vaccination may reduce substantially before autumn. Therefore, the programme is proposing to offer a Spring Booster dose in 2022.

The programme continues to be delivered through a variety of routes including larger scale Vaccination Centres, GP Primary Care providers and Mobile Drive Through sessions. BCUHB teams continue to focus on the most vulnerable and delivery to Care Homes, over 75s and those who are identified as house-bound, are prioritised for the Spring Booster Programme. Regular review of the hard to reach and low uptake areas continues to be undertaken, in an ongoing effort to 'leave no person behind' and tackle potential inequalities.

The Health Board could not have achieved this rate of progress without the support and assistance of many individuals, including:

- Conwy and Flintshire County Councils and Bangor and Glyndwr Universities whose facilities have been the base for our mass vaccination centres.
- Primary care contractors.
- Military services personnel.
- Local authority and North Wales Fire and Rescue staff who have assisted with the running of the vaccination centre booking telephone lines.
- Volunteer vaccinators.
- Volunteers assisting and guiding those attending the vaccination centres.

Wider COVID-19 Immunisation Future Planning
BCUHB are now strategically planning for the future of Immunisation Programmes to deliver a comprehensive, coherent, resourced and efficient and effective Immunisation Programme.

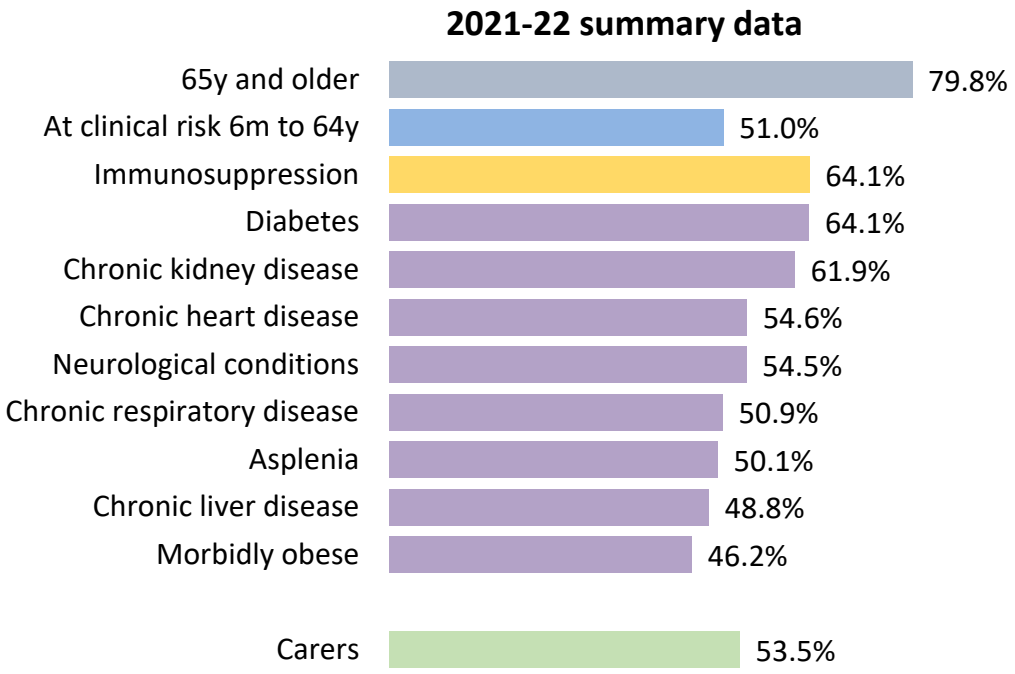
10.2 Seasonal Influenza vaccination programme
In Wales in 2021/22, free seasonal influenza vaccination was offered to a large number of individuals including:

- all those aged over 50 years
- all those aged between 6 months and 49 years under in a clinical risk group
- all pregnant women
- all children aged two years and over, including children in secondary school who became eligible for the first time.
- Care Home and Healthcare Workers

In addition to the above groups, residents of long-stay care homes and those who were the main carer for an elderly or disabled person whose welfare may be at risk if the carer fell ill were offered vaccination. Vaccination of staff working in adult care home settings is an important step to protecting the residents of care homes from the virus, and also ensuring resilience and business continuity in the care home sector, further protecting residents from the impacts of an outbreak of influenza. Care home staff have been eligible to receive a seasonal influenza vaccine via a community pharmacy since the 2018/19 season. The health board has worked closely with care homes regarding the availability of vaccines for their staff and encouraged community pharmacies to work with care homes to support access either at the pharmacy or at the care home premises.

Overall, it was a very positive year as BCUHB reached its highest ever uptake in many groups including those individuals aged 65 years and over at 79.9%. This represents the 2nd highest uptake of vaccines given by Health Boards in Wales. The final data for 2021-22 including a breakdown of the uptake for at risk conditions and also those aged 50-64 years is yet to be published so the data shown below may be subject to change.

Chart showing uptake of seasonal influenza vaccine in BCUHB per eligible group:
Those with immunosuppression are highlighted in yellow in the chart below, as this is the highest uptake of the clinical risk groups.



Source: Public Health Wales, provisional data, correct as of 4.5.2022.
NB: Uptake on pregnant women, carers or those age 50-64 years was not available at the time this report was written.

BCUHB Influenza Strategy for 2022/23

The BCUHB Influenza plan for 2022/23 is now in development. Guidance within the Annual Influenza Strategy correspondence has not yet been published by Welsh Government, however, a Welsh Health Circular on influenza has been published and will aid planning, as it includes information on which influenza vaccines will be issued and which groups are eligible for vaccination. This winter, BCUHB needs to prepare for uncertainty relating to influenza activity and the consequences for next year could be much higher or unseasonal activity may be observed. In 2022/23, achieving a high vaccination uptake will be an important priority to reduce morbidity and mortality associated with influenza and to reduce hospitalisations during a time when the NHS and social care may again be managing the impact of COVID-19 outbreaks.

For 2022/23, the Welsh Government has request a concerted effort to improve influenza vaccination coverage in all groups that are eligible. General practices and school providers must demonstrate 100% offer this season by ensuring all eligible patients have the opportunity to be vaccinated. Ensuring eligible individuals are vaccinated before the influenza virus circulates widely will be a key priority for the BCUHB Influenza campaign. Clusters play a major role in devising plans for their local communities to maximise uptake. All existing strategies implemented during 2021/22 will be implemented again next year, with a renewed focus on supporting clusters to further develop their plans to address the inequalities in uptake and to increase accessibility to the vaccine. There may be opportunities to co-administer with the COVID-19 vaccine should vaccine supply allow.

The majority of the vaccinations will be administered by GPs and school immunisation teams with the support of community pharmacies and district nurses, with the bulk of the work completed between September and December 2022. BCUHB has purchased a contingency stock of vaccine to support delivery of the programme to meet the demand if there is an increase in requests for vaccination.

Childhood Vaccination Programme

Overall performance against the seasonal influenza vaccination target and routine childhood immunisation programme, in comparison to Wales is good, with the Health Board achieving

some of the highest uptake rates in Wales for all categories. It is acknowledged that not all uptake targets have been met and there is work to do to reduce inequalities in uptake across all age ranges.

Staff Influenza Vaccination Plan 2021/22

The staff influenza vaccination programme commenced in September 2021. There was a need to extend the programme in excess of the planned four weeks of intense delivery due to initial low up-take in the vaccine programme across all services. The programme concluded formally on 10th December 2021, however influenza vaccines were still available on request via the local vaccinator programme and from Occupational Health after this timescale.

Influenza priority meetings were held on a weekly basis to monitor uptake and discuss SITREP reporting, and to support weekly actions to increased uptake in line with the target of 80%. An additional vaccination session was added during November to encourage all services and staff to attend for influenza vaccination prior to the COVID-19 booster programme going live. This campaign was met with mixed success; sessions within the Occupational Health Department were very popular with all appointments being used up within the first 72 hours of going live, however, appointments via the local services programmes were readily available and up-take was slow.

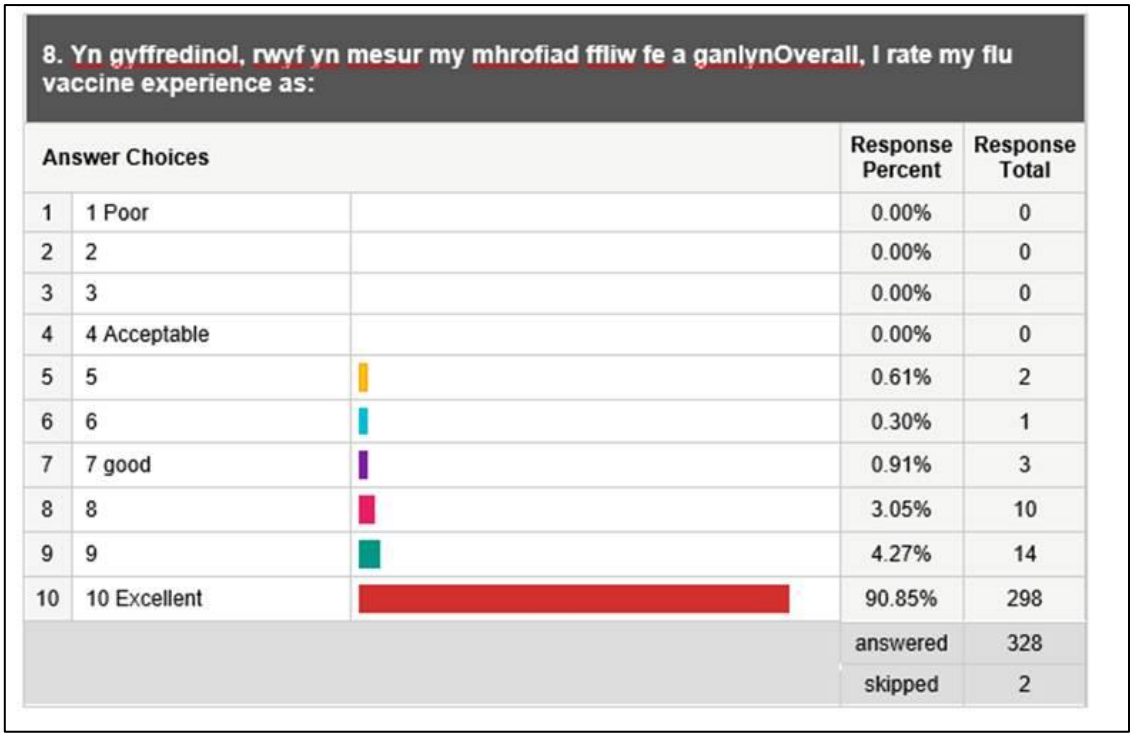
The 365 online booking system proved very successful in supporting staff to attend for their influenza vaccination, with 95% of people who responded to the survey within the Occupational Health Department confirming the booking system was easy to use and helpful, particularly during the ongoing COVID-19 pandemic. It is anticipated that this system will be used to support the 2022/23 staff influenza vaccination campaign.

Staff Influenza Vaccination Data 2021/22

- Total number of BCUHB vaccinations administered to date (Day 113) = 11121.
- % of total number of BCUHB vaccinations administered to date (Day 113) = 59.68%.
- Doses needed to be given to meet target 3786 (target being 14907 - 80%).
- Doses administered to others e.g. Bank/Students/Hospice = 1739 (1008 to BCU Bank).
- Total number of vaccines administered to date (Day 113) = 12860.
- Staff influenza vaccination programme formally finished on 31st March 2022.

The results of the influenza feedback for the sessions held in the Occupational Health department can be found below:

- 98% felt we had communicated the sessions effectively.
- 95% felt the booking system was easy to use.
- 94% felt the venue was easy to access.
- 94% felt the entry to the venue was clear with clear signage.
- 93% felt the vaccinator was proficient.
- 98% felt COVID-safety was ensured.
- 94% felt the staff were welcoming and professional.



8. Yn gyffredinol, rwyf yn mesur my mhrofiad ffliw fe a ganlynOverall, I rate my flu vaccine experience as:

Answer Choices		Response Percent	Response Total
1	1 Poor	0.00%	0
2	2	0.00%	0
3	3	0.00%	0
4	4 Acceptable	0.00%	0
5	5	0.61%	2
6	6	0.30%	1
7	7 good	0.91%	3
8	8	3.05%	10
9	9	4.27%	14
10	10 Excellent	90.85%	298
		answered	328
		skipped	2

10.3 Staff Immunisation and Blood Tests

In 2021/22, the Occupational Health Department carried out over 12,500 immunisations and blood tests on staff.

	Qtr 1 2021/22	Qtr2 2021/22	Qtr3 2021/22	Qtr4 2021/22	Total 2021/22
Immunisations & blood tests BCU	2,412	2,328	1,782	2,973	9,495
Immunisation & blood tests Non-BCU	558	869	927	717	3,071
Total	**2,970**	**3,197**	**2,709**	**3,690**	**12,566**

11.0 Needle stick/sharps/body fluid contamination incidents

The number of needlestick/sharps/body fluid incidents remained relatively static during 2021/22.

	Qtr 1 2021/22	Qtr 2 2021/22	Qtr 3 2021/22	Qtr 4 2021/22	Totals
Number of incidents	95	97	77	96	365
Average per month	31	32	25	32	30
RIDDOR Reportable	0	1	3	0	4

Of the 365 incidents reported, 225 were reported as self-injury, with 47 related to disposal of waste. The activity the incidents were associated with can be found listed within the table below; with the most common activity where an injury occurred being during venepuncture procedure (n~75).

Activity	Number
Assisting colleague with procedure	8
Blood lancet sampling	2

Cannulation	15
Cleaning instruments	15
Dental procedure	15
Disposing of waste	40
General cleaning	4
General Tidying	2
Giving injection	46
Heparin needle [safety]	1
Insulin needle [patient]	7
Insulin syringe & needle [non patient]	1
Intubation	3
Other	47
Scalpel use	1
Scratch / assaulted	8
Spit incident	3
Surgical procedure	38
Suturing	30
Venepuncture	75
(blank)	4
Total	**365**

A BCUHB-wide 'Sharps Newsletter' was widely disseminated in October 2021, which highlighted staff responsibilities, the key risk areas, with a focus on disposal injuries, and what to do in the event of an injury. The Occupational Health team are looking to obtain comparative data from other Health Boards and have a renewed focus on reducing sharps injuries during 2022/23.

12.0 Training in Infection Prevention and Control

12.1 Compliance with Mandatory Infection Prevention Training

Good, comprehensive training in infection prevention and control (IP&C) practice is essential for reducing the risk of the spread of infection and infectious diseases, and maintaining a safe environment for all. The COVID-19 pandemic has further highlighted the importance of infection prevention and control practice across society, and in particular within our public services. All staff within BCUHB are required to have a basic knowledge of infection prevention (level 1 training) but staff responsible for direct care are required to have sound knowledge, understanding and application and must complete level 2 training and assessment.

In 2021/22, BCUHB-wide compliance with mandatory training at level 1 was 84%, with compliance for staff requiring level 2 training at 77.5%, as illustrated in the table below. Estates and Facilities staff had the lowest levels of compliance (level 1- 71%, level 2- 36%), and are exploring options to access funding to support improvement initiatives planned for 2022/23, including digital numeracy and literary training amongst staff and the purchase additional IT hardware (iPad devices) for Domestics, as this staff group do not have access to computers.

IP Level 1	
Area	**Compliance**
Area Teams Central	87.63%
Area Teams East	86.51%
Area Teams West	88.41%

TTP, Vaccinations & Field Hosps	82.58%
Corporate Services	85.39%
Estates and Facilities	71.77%
Mental Health & LDS	87.25%
NW Managed Clinical Services	84.01%
Womens	81.03%
Ysbyty Glan Clwyd	81.53%
Ysbyty Gwynedd	80.40%
Ysbyty Maelor Wrexham	86.01%
Total	**84.10%**

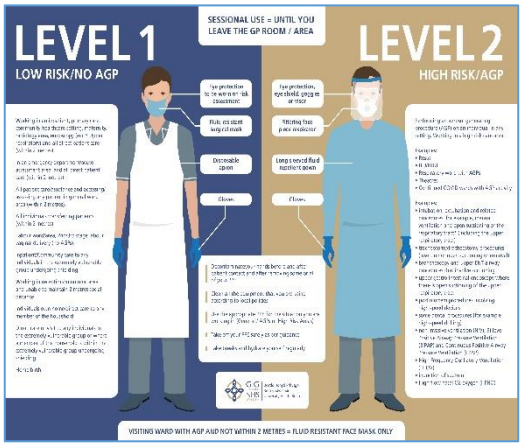
IP Level 2	
Area	**Compliance**
Area Teams Central	79.77%
Area Teams East	79.68%
Area Teams West	82.14%
TTP, Vaccinations & Field Hosps	83.74%
Corporate Services	70.88%
Estates and Facilities	35.65%
Mental Health & LDS	79.80%
NW Managed Clinical Services	76.30%
Womens	74.37%
Ysbyty Glan Clwyd	76.41%
Ysbyty Gwynedd	73.50%
Ysbyty Maelor Wrexham	77.57%
Total	**77.45%**

12.2 Aseptic Non-Touch Technique Training

Aseptic Non-Touch Technique **(**ANTT) training defines the infection prevention methods and precautions necessary during invasive clinical procedures to prevent the transfer of microorganisms from health professionals, procedure equipment or the immediate environment to the patient. ANTT is achieved by maintaining the asepsis (absence of microorganism) of procedure key parts and key sites. All staff undertaking invasive clinical procedures should receive training and assessment in ANTT principles.

In March 2022, BCUHB compliance with ANTT training was 83.5% compared to 88.6% in March 2021. Compliance fell during Quarter 4 due to COVID-19 related work priorities and the staffing challenges that presented. The compliance data has been reported via IPSG, compliance is expected to improve during 2022/23 and will be subject to ongoing monitoring at IPSG. In addition, West Area and Acute have been delivered additional 'Train the Trainer' sessions delivered within departments that were lacking in ANTT assessors. The Infection Prevention Team also supports the Medicines Management Specialist Nurse in delivering ANTT training for intravenous administration of drugs study days on a monthly basis. Furthermore, the Infection Prevention Team are also working with The Association for Safe Aseptic Practice to develop an accreditation programme that is suitable for community nursing teams. One of BCUHB Community Nursing Teams have been involved in the training, assessing and auditing and are close to submission of the relevant documentation for accreditation.

12.3 Donning and Doffing Mandatory Training



Two mandatory modules (level 1 and level 2) for donning and doffing of PPE were launched during Quarter 3; by the end of March, compliance had reached 70%.
Further work continues to improve compliance and support teams completing these modules.

12.4 Infection Prevention Champions

As part of the Safe Clean Care Harm Free Campaign, each ward/department was requested to identify and nominate staff members to the role of the Infection Prevention Champions. The role intends to provide wards/department with ambassadors of good infection prevention practice at ward/department level. Each nominee was invited to attend a training programme which covered the following topics:

- The role of the Infection Prevention Champion.
- Self Care Harm Free - Self assessment.
- Infection Prevention Policies and Procedures.
- Standard Precautions, including isolation.
- Hand hygiene and Bare Below the Elbow policy and procedure.
- Personal Protective Equipment precautions.
- Cleanliness Standards.
- Performing audits and spot checks.
- Communications, campaign materials and the internet.

The full day training programme was delivered via Teams every two weeks. To date, 157 staff have completed the Infection Prevention Champion training with a further 85 staff partially completed the training as outlined in the table below.

	Training Completed	Partially Completed
East	69	50
Central	40	14
West	48	21
TOTAL	**157**	**85**

Due to the COVID-19 pandemic and staffing pressures within the Infection Prevention Nursing Team, training days have been limited since the beginning of 2022. However, the Infection Prevention Team are examining ways of improving the delivery of the programme without impacting on current resources at both Infection Prevention Team and ward/department level and establishing regular ‘drop-in sessions’ to offer support for the champions. Informatics are also developing a Heat map so we will be able to see where we now have Champions and where we still need to target.

12.5 Infection Prevention Massive Open Online Course (MOOC)

As a result of the COVID-19 pandemic and more broadly, the prevention and management of other healthcare associated infections, it is widely recognised that there is a need to further improve existing infection prevention and control practice.
In February 2022 Health Education and Improvement Wales (HEIW) requested that Health Boards recommend and support practitioners to undertake a free level 3 infection prevention training programme (IP MOOC). The programme provides enhanced infection prevention knowledge, understanding and application, and is aimed at registered practitioners and senior level staff in supervisory roles who are responsible for ensuring compliance with good IPC practice e.g. ward and departmental clinical managers.

The MOOC is an online programme run by Bangor University over eight weeks. Each week staff access a different learning unit focused on promoting best practice and behaviours in infection prevention. Each unit requires approximately one hour of time per week. There are two discussion forums to join over the eight-week period and successful completion of the course provides evidence of 10 hours CPD. Individuals can enrol at any time, but the programme is aimed at clinical staff.
Local Infection Prevention Groups were requested to agree which staff should be prioritised, how this can be facilitated and agree targets for completion in 2022/23, subject to places being available.

12.6 Ad hoc Infection Prevention Training sessions
Additional training provided by the Infection Prevention Team was provided on an ad hoc basis as and when the team visited the wards, departments and other healthcare facilities, and upon request. This covered a plethora of infection prevention related topics and regularly included:

- COVID-19 screening and how to perform a screen.
- Correct use of PPE and donning and doffing procedures.
- MRSA, when to screen and how to screen and information about the decolonisation process.
- Carbapenemase Producing *Enterobacteriaceae* (CPE) screening processes, when and how to screen.
- Management of diarrhoea in relation to testing, isolation and completion of the Bristol Stool Chart.
- Use of the Isolation Risk Matrix to assess patients for a sideroom.
- Retrieval of microbiology results via the Welsh Clinical Portal.
- Aseptic Non-Touch Technique (ANTT).

13.0 Infection Prevention and Control Team Audits
During 2021/22, the Infection Prevention Team have continued to respond reactively, focusing much of their time on wards experiencing clusters/outbreaks of infection due to COVID-19. However, despite this and the significant staffing issues within the team, the team have continued to conduct a large number of audits/quality reviews, particularly across acute inpatient areas.

East

- Out of 30 areas in WMH (inpatient areas, day case and admission/assessment areas), at least one full quality review was completed in 29 areas.
- It was not possible to review all outpatient areas with only two reviews performed.
- Diagnostic/Treatment areas such as Endoscopy and Theatres were reviewed, however Radiology remains outstanding and are now a priority for review in Quarter one in 2022/23.
- All Community Hospital wards had at least one review performed (eight in total).
- Four of five of the Mental Health wards were reviewed in addition to the two Substance Misuse Clinics and the bungalows.
- Other areas reviewed include HMP Berwyn, the Artificial Limb and Appliance Centre, Breast Clinic and Podiatry, two COVID-19 vaccination centres and one COVID-19 testing unit.
- It has not been possible to review the Depot and Clozapine Clinics, Intravenous suites within Community Hospitals, Renal Satellite Unit and the Mental Health Day Unit.
- Reviews were completed in two out of four managed GP practices.
- It was not possible to review any of the 20 Care Homes.

Central

- Out of 36 areas in YGC and Abergele Hospital (including inpatient areas, day case and admission/assessment areas), at least one full quality review was completed in 28 areas.
- It was not possible to review any outpatient areas.
- All theatres within YGC were reviewed, however it was not been possible to review Theatres in Abergele Hospital and the Radiology department remains outstanding in YGC and are now a priority for Quarter 1 in 2023
- Four of the nine Community Hospital wards had at least one review performed and one of the two Minor Injury Units was reviewed.
- No reviews have been performed within the Mental Health unit and Substance Misuse Clinics; these are a priority for 2022/23.
- It was not possible to review any of the four GP managed practices.
- It was not possible to review any of the 37 care homes.

West

- Out of 26 areas in YG, (including all inpatient areas, day case and admission/assessment areas), at least one full quality review was performed in 17 areas.
- It has not been possible to review outpatient areas.
- Theatres and Radiology remain outstanding and a priority, however Endoscopy received a full review.
- All community hospital wards had at least one full review (seven in total).
- Of the 11 Mental Health wards/units, 10 received a full quality review, with one out of three Substance Misuse Services also reviewed.
- It has not been possible to review the Depot and Clozapine Clinics.
- Three out of four managed GP practices were reviewed.
- Out of 25 Care Homes, 16 were reviewed.

During ad-hoc visits to the wards/departments whether to provide advice, education or to review a patient and/or the environment following an infection, the Infection Prevention Team performed spot checks and provided feedback to ward staff in real-time. In addition, hand hygiene audits, mattress audits and commode audits are completed as a quality check against the mandatory audits performed by the ward/department staff.

It has remained difficult to analyse the health board data associated with some of these audits due to an inconsistent approach in recording the data, with some areas recording on paper only and others recording electronically. An extensive piece of work has been carried out by the Informatics team to make the hand hygiene and commode audits electronic, standardising the audit process across the board. The new electronic audit tools will allow us to report audit compliance going forward to support change in practice and improvement where required.

The Informatics Team continue to progress this work to make other audit tools e.g. mattress audit electronic.

14.0 Estates and Facilities

14.1 Environmental Cleaning Services 2021-22

The cleanliness of any healthcare environment is important for the prevention of the spread of infection and patient safety and well-being. Furthermore, the cleanliness of an environment can contribute to the overall quality of a patients experience. All Health Board staff have a responsibility for the cleaning and maintenance of their workplace and have a role to play in providing continuous improvement in environmental cleanliness. The National Standards of Cleaning, Wales (2009) set out the cleanliness requirements for all Health Boards in Wales.

As part of the response to COVID-19, an addition to the present National Standards of Cleaning (Wales) has been issued under the title, COVID 19, Enhanced Cleaning Addendum; this relates to Domestic, Estates and Nursing cleaning responsibilities.
The National Standards for Cleaning, Wales (2009) stipulate that continuous monitoring of environmental cleanliness is undertaken. Credits for Cleaning (C4C) is the agreed auditing tool for use in all Health Boards in Wales.

Management Arrangements
All cleaning services are provided by the BCUHB Estates and Facilities Service as a managed in-house service with the substantive management structure remaining unchanged in 2021/22. In addition, an interim Hotel Services Manager, band 7 position has been recruited to support the implementation of the COVID-19 addendum, which was made a permanent position from 1st April 2022.
The management team continually strive to maintain and deliver a quality Domestic Service throughout the Health Board. The Domestic Services Departments work closely with the Hospital Management Teams (HMT), have daily representation at the hospital huddle meetings and are in regular contact with the Infection Prevention Team.

Budget Allocation
The cleaning service is allocated a revenue budget on an annual basis. For 2021/22, the overall budget for the service was £16,162,903. Preparation of capital and revenue investment cases and costings are supplied by the Hotel Service Teams for approval by the Estates and Facilities, Senior Management Team. Additional Revenue of £150,000 has been provided in Quarter 4 to support the purchase of additional cleaning equipment for use BCUHB-wide.

A financial request was approved by the Health Board in July 2021 to support the implementation of the COVID-19 Cleaning Addendum guidance. The bid equated to £2.7 million, consisting of £2.5m pay and £200,000 non-pay budgets. A programme of recruitment to Domestic Team posts commenced in September 2021 to support implementation requirements of the guidance and consisted of:

- 3 Domestic Supervisors
- 96 Domestic Assistants
- 6 Deep Clean Operatives (Ventilation grille Cleaning)

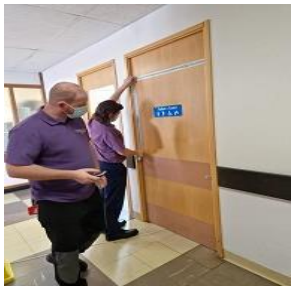
The additional revenue funding will form part of the Facilities budget for 2022/23 on a recurrent basis.

Cleaning Responsibilities Framework
The BCUHB Cleaning Responsibilities Framework document for secondary care and Community Hospitals was approved and implemented as part of the Safe Clean Care Programme. In March 2019, a Cleaning Responsibilities Framework was developed for use in GP, Health Centre premises and HMP Berwyn.
The framework was introduced to provide clear guidance on which staff group had responsibility for cleaning items of equipment; in cases where enhanced or specialist cleaning is required this is undertaken by the Domestic Services Deep Clean Teams. The framework is reviewed on a regular basis, with discussions taking place during 2021/22 regarding rebalancing frameworks activities from Nursing to Domestics to align cleaning processes that are undertaken by both staff groups.

Service Continuity/Improvement
The domestic services management team have been undertaking a continuous review during 2021/22 of cleaning processes and procedures in response to new guidance issued (as mentioned above) which has been issued in respect of the management of environmental cleanliness. This has required a gap analysis to inform the resource gaps between the National Cleaning Standards for Wales and the COVID-19 cleaning guidance. Additional

revenue was provided in Quarter 4 to purchase cleaning materials and equipment, which has allowed large floor care and other associated cleaning equipment to be purchased which would normally be outside the scope of the annual cleaning equipment financial allocation.
Additional Deep Clean and Night Domestic Services have been enhanced to support additional demand, especially in response to Emergency Department frequencies of cleaning.
Bank and fixed term staff have previously been employed but now form permanent positions as part of the agreed Domestic Team establishment.
The Domestic Services Management team have been playing an active role throughout 2021/22 within the Association of Healthcare Cleaning Professionals at a regional and national level.

Enhanced and new cleaning processes
Domestic Services continue to use hydrogen peroxide vapour (HPV) and ultra violet light (UVC) decontamination methods as part of the enhanced cleaning processes following the discharge of patients with a healthcare associated infection (e.g. *C.difficile*) or outbreaks. Proactive preventative cleaning has been undertaken as part of the reopening of wards and on a rolling deep cleaning programme in the Wrexham Maelor Hospital. Due to the increased requirement for enhanced cleaning, additional HPV equipment was hired during 2021/22 to support the present equipment stock.

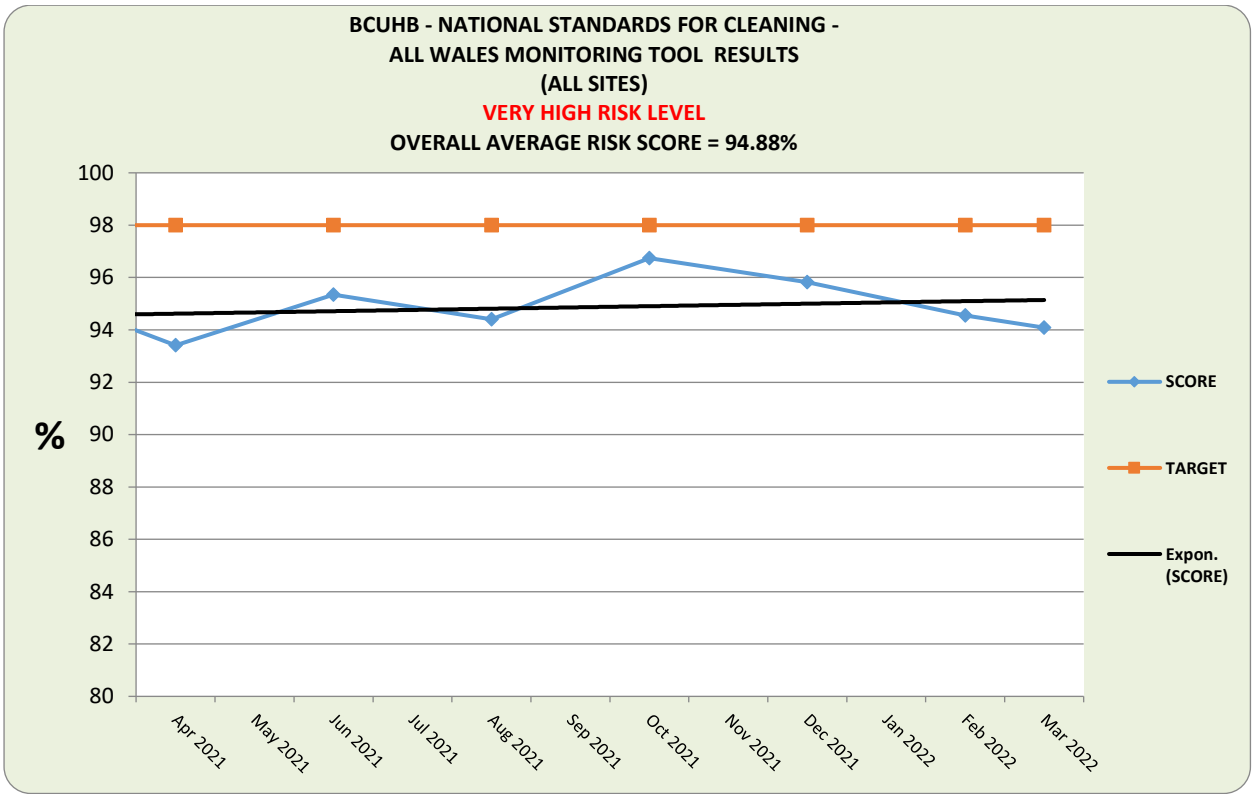



During 2021/22, the Domestic Services Team (west) have undertaken extensive trials to determine alternatives to the use of HPV due to critical factors (such as time constraints and health and safety requirements), which affect its usage outside of the three main hospital sites. The Health Board has trialled an alternative, Hypochlorous Acid, with an initial eight systems purchased in March 2022. The key advantages of Hypochlorous Acid are that the time taken to undertake the process is less than HPV, Health and Safety issues are reduced and it is more cost-effective.

Monitoring
Monitoring continues to be undertaken in accordance with the National Standards for Cleanliness in Wales (2009), using the Credits 4 Cleaning Audit Tool. The Domestic Supervisors facilitate the audit process with support from nursing and estates colleagues.
All Hospital Management Teams, Senior Nursing, Ward Matrons/Departmental Heads are provided with the cleaning results at the time of audit for their own areas and on a monthly basis as part of wider distribution.
Due to COVID-19, the frequency of audits has been intermittent due to restricted access to clinical areas and departments.
The Credits 4 Cleaning audit tool has been in use in the Health Board since 2005. In February 2022, the audit tool was upgraded to the MiCad Audit System, which enhances the auditing and reporting functions available to the Health Board.

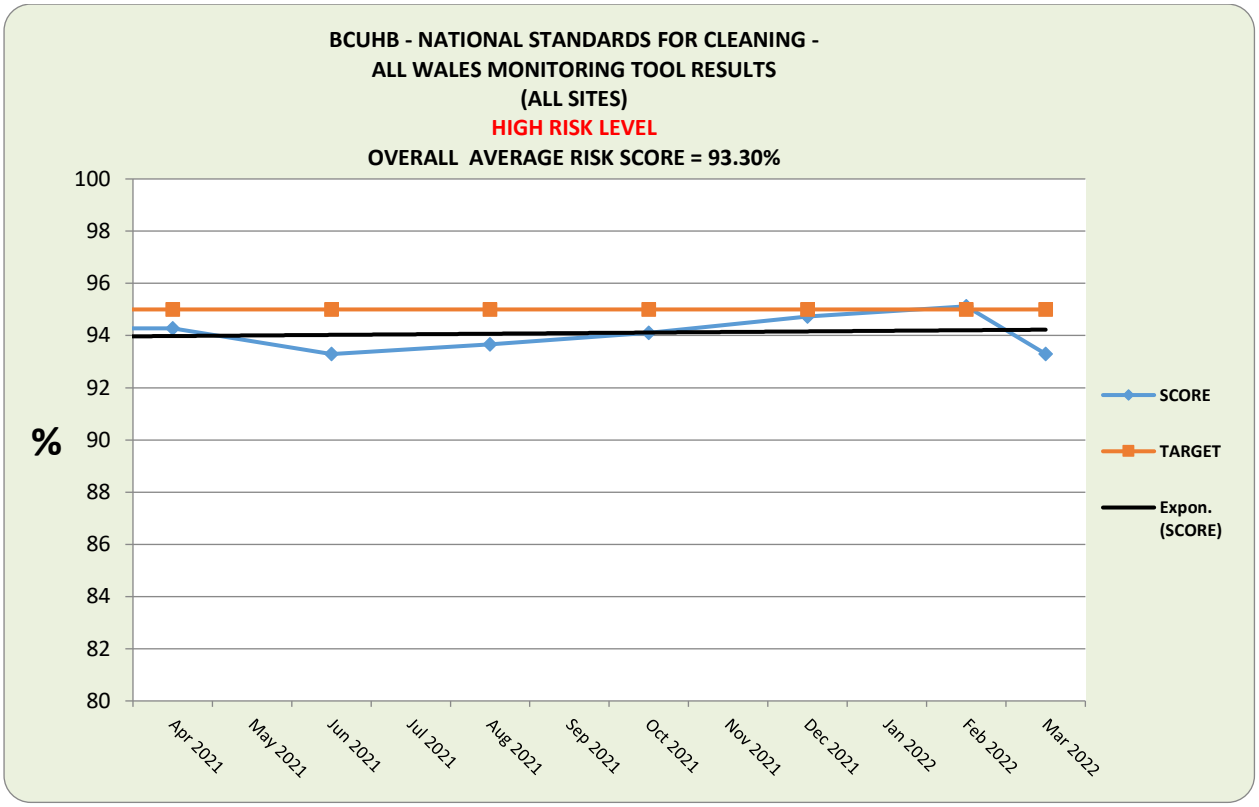



Average results for all sites for Very High Risk and High Risk Areas for 2021/22 are shown below:



Very high risk functional areas include operating theatres, ICUs, SCBUs, accident and emergency (A&E) departments, and other departments where invasive procedures are performed or where immuno-compromised patients are receiving care.

High risk functional areas include general wards (acute, non-acute and mental health), sterile supplies, public thoroughfares and public toilets.



Furthermore, systems to test the efficacy of cleaning (Adenosine Trisphosphate- ATP and CiFi torch technology) were trialled during 2021/22 and further work during 2022/23 will be undertaken to consider appropriate usage and roll out.

ATP (Adenosine triphosphate) testing is used to measure levels of ATP on a surface. Testing is done after a surface has been cleaned and indicates the efficiency and effectiveness of the cleaning being done, and therefore the cleanliness of the environment.

The CiFi torch is an instrument that can locate human biological traces, bacteria and organic matter that cannot be seen with the naked eye, and therefore supports cleaning and facility management staff to achieve forensic standard results

Resource Establishment

Due to high rates of absence caused by COVID-19 (sickness, isolation and shielding issues), the service had to recruit high numbers of additional bank staff above the normal establishment using a fast track system, ass illustrated in the table below:

Band	Title	Establishment	
		Budget	Actual
7	Hotel Services Manager	3	6
5	Assistant Hotel Services Manager (Domestics)	3	3
3	Domestic Supervisor	26.95	27.98
2	Domestic Assistant	511.65	521.05

Figures as per the 31st March 2022

Focus has also been placed on the recruitment of new Domestic Assistants to support the COVID-19 Addendum guidance supported by workforce and recruitment colleagues. It was envisaged that the full establishment would be achieved by the end of the March 2022, but due to the present employment market and a large amount of out of area applicants, recruitment is still ongoing.

14.2 Water

BCUHB uses in excess of 515,000m3 (figure based on consumption 2020-2021) of water during the course of a normal year, which is provided for by Local Water Authorities' (Welsh Water and Harfen Dyfrdwy).

The water system and functions on site range from the provision of potable water supplies, tank fed water supplies and specialist 'treated' water supplies providing for process plant and medical equipment.

The management arrangements for Water Safety Systems within BCUHB are contained within ES02 Policy for the management of Safe Water Systems.

Guidance on the management arrangements is contained within Welsh Health Technical Memorandum (WHTM 04-01) and HSG274.

During 2021/22 the Water Safety Group have supported a number of redevelopment project and small minor works projects in providing comments on design standards and the installation of equipment that connect to the water infrastructure.

The Policy for the Management of Water Safety is an overarching document to ensure that the arrangements for the safe management of water systems are clearly identified within BCUHB and that the policy document identifies the controls and hierarchy required to ensure that water systems are safe. To support the Water Management Policy, there is a requirement that local water management procedures be in place for all BCUHB premises, in each operational area, instigated and managed by the relevant Area Responsible Person. The current policy has been updated to reflect changes within the organisation and was presented for approval in quarter 1 of 2022/23.

In accordance with the Policy for the Management of Safe Water Systems, a Water Safety Plan (WSP) has been developed to set out how the risks from microbiological hazards associated with the supply and use of water are assessed, understood, managed and controlled for buildings within our estate. The Plan has been reviewed by the Water Safety Group and was presented for approval to the Infection Prevention Sub-Group alongside the updated Policy in quarter 1 of 2022/23.

The key function of the Water Safety Plan is to:

- Ensure the Operational Estates maintenance strategy is aligned with current standards.
- Provide guidance on department's responsibility to ensure a safe water system.
- Introduce a procedure for reporting and recording activities that affect water quality within the Health Board.

NHS Wales Shared Services, Special Estates Services Authorising Engineer (Water) Annual Report

The Authorising Engineer is appointed by the Deputy Duty Holder (Director of Estates and Facilities) and is a named representative of the NHS Wales Shared Services Partnership, Specialist Estates Services Team. They conduct an annual review/audit of operational procedures and compliance and submit a report to the Water Safety Group. The report for 2021-2022 reported a compliance rating of Yellow, which shows an improved position since 2019 as illustrated below.

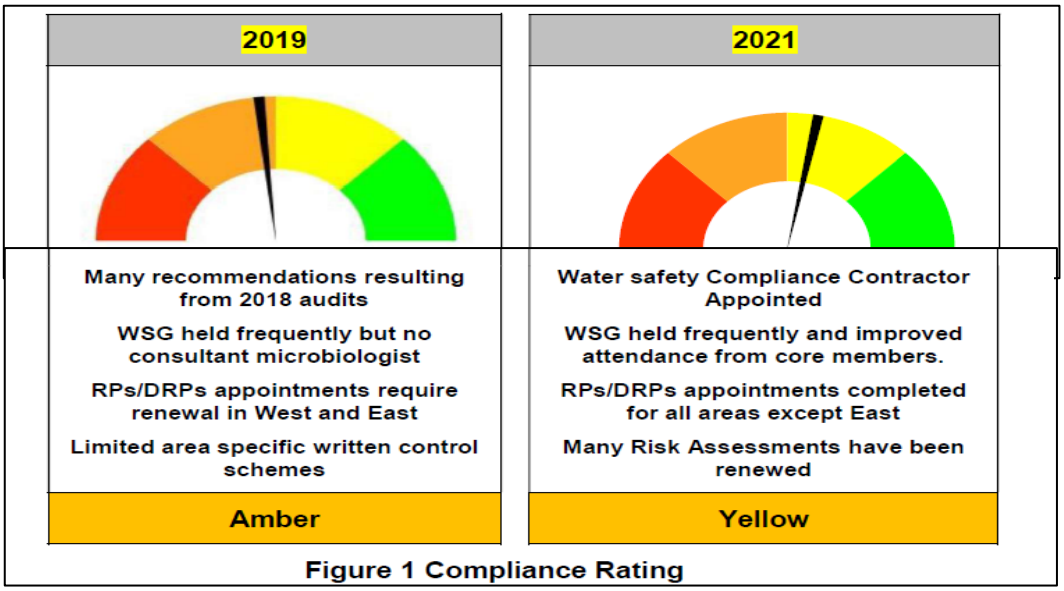


Figure 1 Compliance Rating

14.3 Ventilation

BCUHB acknowledges its responsibilities under the Health and Safety at Work Act 1974 and supporting legislation relevant to this discipline, (including The Control of Substances Hazardous to Health (COSHH) Regulations 2000 and subsequent approved codes of practice such as L8 and published guidance documentation such as Health Technical Memorandum (HTM) 03-01 Specialised Ventilation Systems for Healthcare Premises and HTM 04-01, The Control of Legionella), to ensure that it meets the criteria and standards for Ventilation Systems within its control.

The management arrangements for ventilation systems within BCUHB are contained within ES05 Policy for the management of Ventilation Systems, which was reviewed during 2021/22 is currently in the process of being approved by the Health Board. Guidance on the management arrangements is contained within Welsh Health Technical Memorandum (WHTM 03-01).

The Policy for the Management of Ventilation Systems was developed to ensure compliance with existing legislation, helping ensure that good practice standards are applied to all ventilation systems in use within the organisation. The Policy will not only ensure the organisation complies with the law, it also fosters confidence amongst both public and staff that the organisation takes its responsibilities regarding maintenance of these systems seriously. This Policy will provide guidance to those responsible for the management of ventilation systems and will ensure that adequate liaison is established between key members of staff and persons with overall responsibility for maintenance management.

During 2021/22, the Ventilation Safety Group has supported redevelopment projects and reviewed information on verification of critical ventilation systems, examples of such support are listed below:

- Support to the design principles for Wrexham Community Dental Services Ventilation Project.
- Receive assurance reports from Operational Estates on compliance of Critical Ventilation Systems in areas including theatres and critical care wards.
- Commence with a review of Non-Critical Ventilation Systems in general ward areas etc.
- Commence a review of Ventilation Systems within Decontamination Facilities including Sterile Services Departments.
- Working with EcoLab in piloting the use of air purifiers within ward areas in 2022.

To improve ventilation in existing Healthcare premises, short term actions that can be taken are limited and include:

- Leaving windows open whenever possible, and opening and closing windows for typically 5 to 10 minutes every hour throughout the day during cold weather, to improve natural ventilation and purge airborne contaminants.
- Changing windows to improve their design and opening areas, again to improve natural ventilation.
- Provide good cross flow ventilation and open doors when practical to improve ventilation.
- As a final option, if the above measures cannot be implemented effectively, consider installing HEPA/UVC air cleaners to supplement existing ventilation in areas that are poorly ventilated.

Longer term options to improve ventilation include the following:

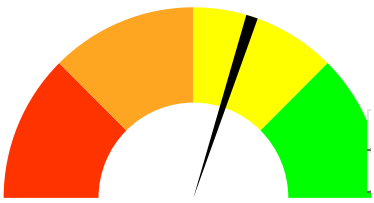
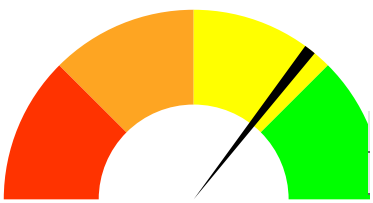
- Install new mechanical ventilation systems in accordance with the guidance given in the new version of HTM 03-01 Part A (2021).
- Install ventilation systems based on future guidance that utilises a combination of fresh air, mechanical ventilation and air cleaning technologies, including HEPA & UPVC technologies.
- Install additional negative pressure isolation suites in accordance with WHC 033 (2018).
- Create new isolation wards / facilities in acute hospitals, in line with the guidance given in the *"Operational guide for the transition of healthcare environments in preparation for Autumn/Winter 2021/22 incorporating COVID - 19 Measures",* recently published by Welsh Government.

Next Steps for 22/23

- Ring-fence £50,000 of SCC funding to commence with a ventilation strategy for non-critical ventilation systems (Result - Quarter 3).
- Review the use of Air Purifiers with integrated UVC technology in Hebog Ward at Ysbyty Gwynedd (Result - Quarter 1).
- Work in partnership with Clinical Team in Central Area to review ventilation within Community Ward Areas (Result - Quarter 1).

NHS Wales Shared Services, Special Estates Services – Authorising Engineer (Ventilation) Annual Report

The Authorising Engineer, Ventilation is appointed by the Deputy Duty Holder (Director of Estates and Facilities) and is a named representative of the NHS Wales Shared Services Partnership, Specialist Estates Services team. They conduct an annual review/audit of operational procedures and compliance and submit a report to the Health Board. The report for 21/22 reported a compliance rating of Yellow, which shows an improved position since 2020 as illustrated below.

2020	2021
	
Additional APs appointed but no APs at YGC No CPs appointed	**Additional APs appointed but more APs are required. No CPs appointed**

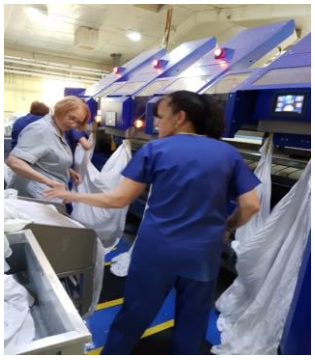
Governance largely in place Procedures are being implemented Risks identified Action plans pending funding, with progress where possible	**Governance largely in place Procedures are being implemented Risks identified Action plans pending funding, with progress where possible**
Yellow	**Yellow**

14.4 NWSSP Linen Services

The North Wales Laundry is located on the Glan Clwyd acute site and run as part of the All Wales Laundry Service (North Wales Shared Services Partnership). The Laundry provides linen services for all Health Board sites and Wales Ambulance NHS Trust sites in North Wales. The service is used by all clinical wards and departments within the Health Board. The Laundry produces over six million individual pieces of linen per year.
The below table details the breakdown of linen items processed in 2021/22:

Item	Number	Item	Number
Sheets	1,494,344	Scrub Tops	208,260
Pillowcases	724,156	Scrub Bottoms	205,598
Counterpanes	204,040	Linen Bags	2,862
Blankets	554,604	Curtains	10,894
Towels	760,823	Staff Items	12,285
Patient Gowns	386,774	Miscellaneous Items	355,049
Draw Sheets	22,119	Mattresses	1,034
Dignity Sheets	75,769	Baby Items	51,964
Nightgown	25427		
PJ Tops	24,582		
PJ Bottoms	25,977		
Total: 5,146,561 items based on the 2021/22 outturn figures			

The following additional items have been processed in 2021/22 as part of Microfibre cleaning:
Total: 1,102,398 Cloths/Mops per annum on the 2021/22 outturn figures.


North Wales Linen Services transferred from BCUHB to NWSSP on the 1st April 2021. The factory will remain on the YGC site until a new facilities opens in 2025.

14.5 Waste Management

During 2021, due to the COVID-19 pandemic, all waste general, recyclable and clinical was required to be placed in orange clinical waste bags for disposal. This resulted in excessively high volumes of clinical waste, storage issues, collection issues with the All Wales Clinical

Waste Contactor, increased costs and incorrect segregation, which has had an enormous impact on Health Board sites.

COVID-19 Waste Management Standard Operating Procedure version 2 June 2021 was not been fully implemented; resulting in BCUHB not being fully compliant with the Standard Operating Procedure and waste legislation, clinical waste volumes have increased impacting on Health Board sites and increasing costs. Work is ongoing during 2022/23 to re-introduce clear bags to reduce clinical waste volumes in all areas.

- Ysbyty Glan Clwyd reintroduced clear bags on 31st January 2022.
- Communication has started to progress the reintroduction of clear bags on site Wrexham Maelor Hospital.
- Ysbyty Gwynedd have reintroduced clear bags in some non-clinical and clinical areas during Quarter 1 of 2022/23

Following collection, clear bag waste is compacted prior to collection by Veolia and taken to a Material's Recovery Facility where recyclable waste is segregated for recycling. For waste that cannot be recycled, it is transported to a Refuse Derived Fuel facility where it's incinerated to create energy. New compactors were installed at each District General Hospital in June 2021.

Picture: Compactor at Wrexham Maelor hospital.

Cardboard is segregated and baled for recycling. The Health Board receives a rebate for bales and recycled over 100 tonnes of cardboard in the last year.

Pictures above show cardboard baler and bales at Wrexham Maelor hospital.

Clinical Waste

Site	AHT Tonnage	AHT Cost	Incineration Tonnage	Incineration Cost
Wrexham Maelor	642.50	£195,872.55	65.18	£27,136.20
Ysbyty Glan Clwyd	689.16	£197,353.83	110.350	£37,298
Ysbyty Gwynedd	585.40	£181,878	52.437	£22,285.38

General Waste

Site	Landfill Tonnage	Landfill Cost	Recycled Tonnage	Recycled Cost	RDF Tonnage	RDF Cost
Wrexham Maelor	2.71	£508.83	134.36	£21,053.45	236.04	£39,784.52
Ysbyty Glan Clwyd	14.29	£3,580.19	89.91	20,402.22	181.67	£31,671.54
Ysbyty Gwynedd	0.287	£59.14	106.33	£19,394.51	183.84	£27,294.13

Waste Audits

The following waste audits have been completed and results feedback to the individual departments and management teams:

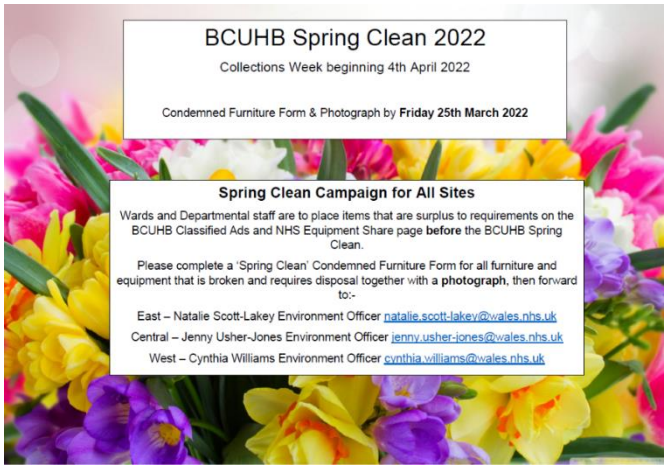
Type of Audit	Company/Site	Date
Duty of Care Audit	Stericycle - Telford	September 2021
Duty of Care Audit	Refoods	March 2022
Pre Acceptance Waste Audit- Central Area	RAH Child Development Llanwrst Clinic St Asaph Clinic	April 2021 April 2021 June 2021 June 2021

	Abergele Clinic Roslin YGC Colwyn Bay Hospital Bryn Hesketh Unit Maes Derw Clinic Ffordd Las Clinic Abergele Hospital Llandudno Hospital	June 2021 July 2021 Sept 2021 October 2021 November 2021 November 2021 November 2021 January 2022 January 2022
Pre Acceptance Waste Audit- East Area	Chirk Hospital Gresford clinic Mold Hospital Deeside Hospital Wrexham Maelor hospital Holywell Hospital	May 2021 May 2021 May 2021 October 2021 November 2021 February 2022
Pre Acceptance Waste Audit- West Area	Bryn Beryl Hospital Alltwen Hospital Cefni Hospital Ty Cegin, Bangor Plas Brith Dolgellau Penrhos Stanley Hospital Tywyn Hospital Ysbyty Gwynedd Microbiology YG Bryn Y Neuadd Hospital Ebeneser Centre, Llangefni	April 2021 April 2021 November 2021 November 2021 November 2021 January 2022 February 2022 February 2022 February 2022 March 2022 March 2022

The Health Board awarded two new contracts during 2021/22. One was in relation to collection and disposal of recyclable, domestic and general waste and commenced on the 1st June 2021; is a five year contract with an option to extend for a further 24 months. The second contract related to the disposal of food waste, which commenced 7th January 2022; is a three year contract with an option to extend for a further 24 months.

Autumn/Spring Clean 'de-clutter'

The Health Board's Autumn Clean and Spring Clean 'de-clutter' campaigns were a great success which encouraged wards and departments to clear clutter and unused items, improving tidiness and easing the cleaning of their areas and supporting our efforts to maintain a safe, clean environment.



14.6 Risk Register

A number of infection prevention related risks are part of the Operational Estates Risk Register, are reviewed regularly. Specific elements included are ventilation and control of contractors.

ID	Ref	Handler	Title	Opened	Closed date	Risk Type	Risk level (current)	Risk level (Target)	Risk Rating (current)	Date of Last Review/Update	Date of Next Review	Area/Secondary/Corporate
3157		Mr Rod Taylor	There is a risk that patients may be harmed and could die as a result of insufficient Oxygen supply during Covid-19 surge.	21/04/2020		Tier 3 - (Current Score 1-8)	Low	Low	3	25/01/2022	28/02/2022	Estates and Facilities (PandP)
4255		Mr Rod Taylor	Facilities Department - Structural Risk	23/12/2021		Tier 2 - (Current Score 9-12)	High	Moderate	12	20/01/2022	28/01/2022	Estates and Facilities (PandP)
3020	CRR20-02	Mr Rod Taylor	Contractor Management and Control	07/01/2020		Tier 1 - Corporate Risk (Current Score 15-25)	Extreme	High	15	23/02/2022	08/03/2022	Estates and Facilities (PandP)
3019	CRR20-01	Mr Rod Taylor	Asbestos Management and Control	07/01/2020		Tier 1 - Corporate Risk (Current Score 15-25)	Extreme	High	15	23/02/2022	08/03/2022	Estates and Facilities (PandP)
2451	Estates REF OEE037	Mr Arwel Hughes	Electrical Infrastructure Community Hospitals - Estates Operational Engineering	11/12/2018		Tier 2 - (Current Score 9-12)	High	Moderate	9	18/01/2022	31/03/2022	Estates and Facilities (PandP)
3948		Mr Rod Taylor	Reduction of Estates & Facilities Staff Capacity	25/05/2021		Tier 3 - (Current Score 1-8)	Moderate	Moderate	6	18/01/2022	31/03/2022	Estates and Facilities (PandP)
3238		Mrs Helen Roberts	Impact of Staff absences on support capability	06/05/2020		Tier 3 - (Current Score 1-8)	Moderate	Moderate	4	25/01/2022	31/03/2022	Estates and Facilities (PandP)
2724	2724	Barry Williams	Duct work and fire compartmentation	07/05/2019		Tier 2 - (Current Score 9-12)	High	Low	9	25/01/2022	31/01/2022	Estates and Facilities (PandP)
2450	Estates REF OEE034	Mr Arwel Hughes	Nurse Call Bell - Estates Operational Building	11/12/2018		Tier 2 - (Current Score 9-12)	High	Moderate	9	18/01/2022	31/03/2022	Estates and Facilities (PandP)
2448	Estates Ref OEE019	Mr Arwel Hughes	General Ventilation - Estates Operational Engineering	11/12/2018		Tier 3 - (Current Score 1-8)	High	Low	8	25/01/2022	31/01/2022	Estates and Facilities (PandP)

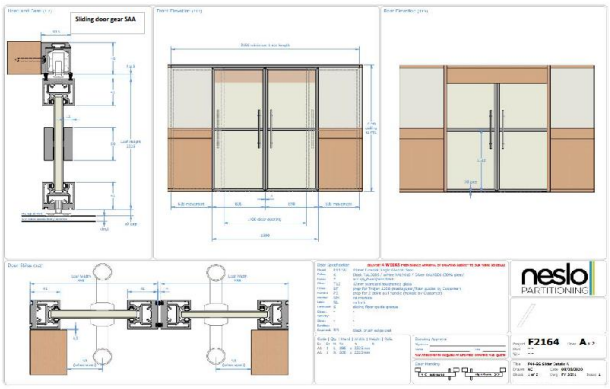
14.7 Environmental Improvement Works

The Operational Estates Department within BCUHB received £500,000 discretionary capital funding within 2021/2022 to improve the hospital environment. The focus of the programme was to improve C4C Audit scores and upgrade the ward/department environment. The project was presented to each Local Infection Prevention Groups for approval. Three different work stream were developed based on geographical responsibility within Operational Estates. Improvements included:

- Installation of bay doors at Ysbyty Gwynedd
- Installation of bay doors at Llandudno General Hospital
- New wash hand basins at Wrexham Maelor
- New flooring at Colwyn Bay Hospital
- Works at Glan Clwyd ED
- Clutter free clinical areas

Operational Estates Department – West

Following the Outbreak review that was carried out at Ysbyty Gwynedd it was identified that 4/6 bedded bays within admission wards required doors to aid with segregation of patients.



Status of current programme and remaining works for Ysbyty Gwynedd are detailed within the table below:

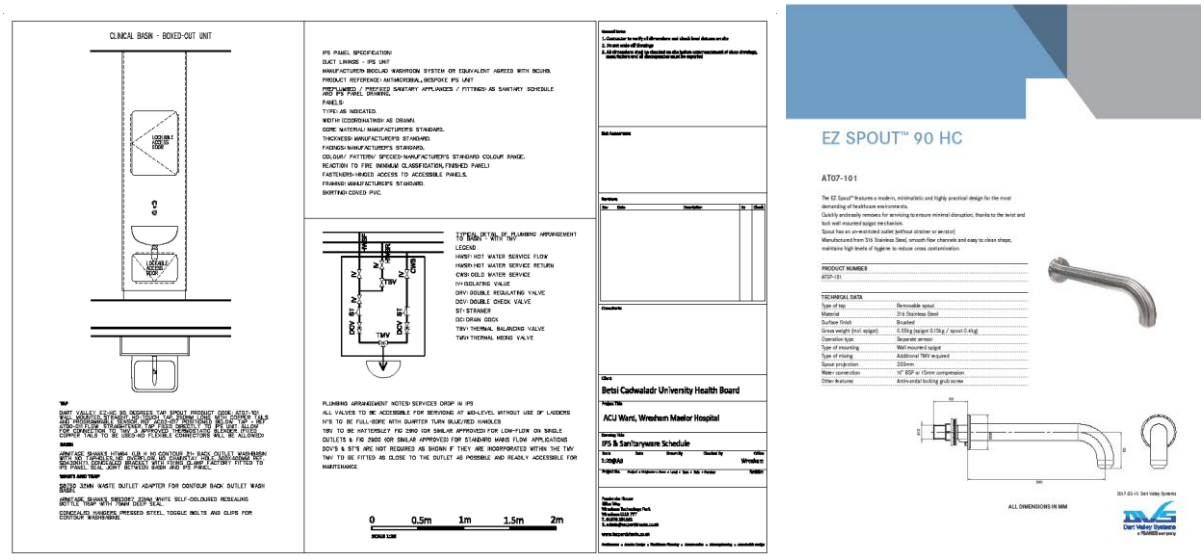
WARD	A BAY	B BAY	CORRIDOR	C BAY	D BAY
MOELWYN					
HEBOG					
PRYSOR					
GLASLYN					
FFRANCON					
LLIFON					
DEWI					
MINFFORDD					
ARAN					
GOGARTH					
TRYFAN					
GLYDER					
CONWY					
OGWEN					
TEGID					
DULAS					
ENLLI					
TUDNO					

Key:

	Bay doors installed
	Bay doors not yet installed
	N/A

Operational Estates Department - East

Following an inspection of Clinical WHB provision by Senior Nursing Leads, Infection Prevention Team and Operational Estates, a programme of works was agreed to install additional wash hand basins within the Wrexham Maelor Site and Community Hospitals.



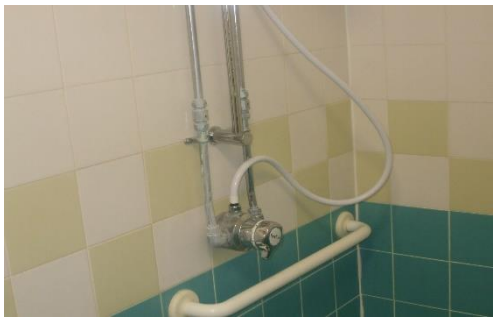
The detail of location of Clinical Wash Hand Basins installed is listed in the table below:

Hospital	Location	Number Installed	Number Outstanding
Heddfan Unit	136 Suite	1	0
Deeside Hospital	Ward Area	2	0
Mold Hospital	Ward Day Rooms	2	0
Wrexham Maelor Hospital	Various areas	19	11

Operational Estates Department – Central

Within Ysbyty Glan Clwyd, the Safe Clean Care project focused on two areas within the acute site; Emergency Department and North Wales Cancer Services. Within the Oncology Department, a project was developed to replace water outlets which were being reported as matters of escalation as part of the Pseudomonas Reporting at the Water Safety Group. Showers were replaced and additional wash hand basins were installed to improve hand hygiene practices. The below photos demonstrated the work carried out which will improve compliance within the unit.

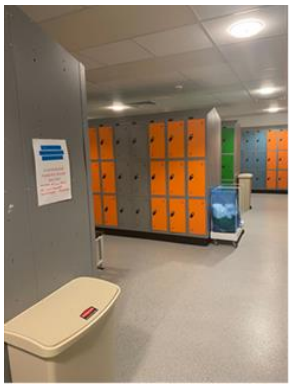
Shower improvement project photographs:

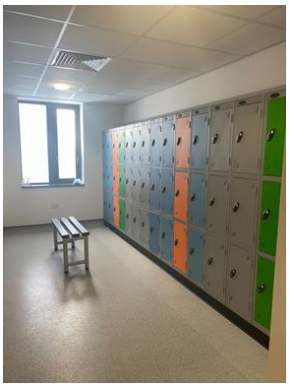


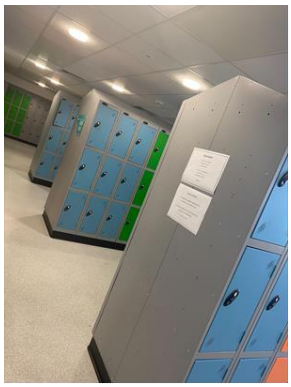
There have also been Improvement to changing facilities at YGC:

Previous changing facilities:

New changing facilities:





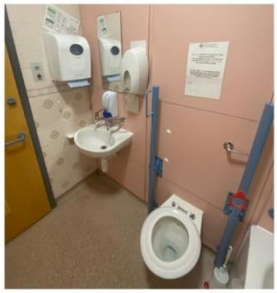
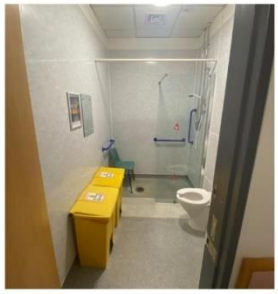


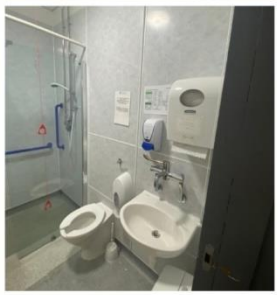
And refurbishment of the maternity ward:

Ward area pre-refurbishment


Ward area post-refurbishment


Bathrooms pre-refurbishment



Bathrooms post-refurbishment




14.8 Looking ahead to 2022-2023

Estates and Facilities Division – Discretionary Capital Fund

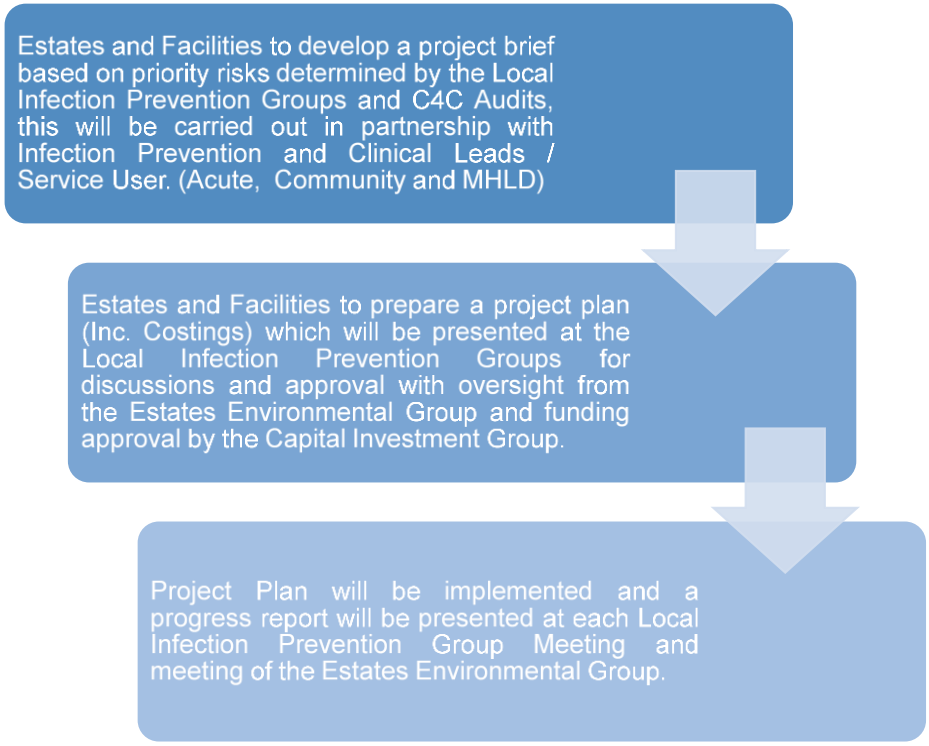
Safe Clean Care - Programme

2022-2023

The funding will be allocated based on identified environmental risks for both Estates and Facilities taking into account C4C Audit reports and recent Infection Prevention reviews.

- Central Acute and Area - £300K
- East Acute and Area - £300K
- West Area - £300K

The process to approve all projects will be as detailed below:



14.9 Food Safety

The Health Board introduced a BCUHB Primary Authority Scheme (PAS) agreement between Wrexham County Council (WCC) and the Health Board in 2016 originally on a 3 year agreement which was retendered in 2020 for a further 3 years with WCC, prior to this food safety was monitored by the 6 different Local Authority, Environmental Health Teams across North Wales. This did not allow standardisation for BCUHB in relation to food safety policy and process. BCUHB Facilities Management Services have developed over the last 3 years in partnership with their Primary Authority Scheme provider a robust food safety system which merged 21 food safety policies and associated documentation into one.

The objectives which formed the agreement of activity to be undertaken in partnership between the primary authority and the Health Board are:

- To provide expert advice with the updating of the BCUHB Catering Strategy in relation to the Food Safety Act and associated regulations and guidelines. The

PAS advises on the strategic direction for both Acute and Community Hospitals which may require different methods of food delivery dependant on the type of patient. The advice will also include satellite ward/department and retail catering.

- To support the maintenance of the BCUHB Food Safety Management System to cover both primary and satellite catering facilities to achieve the performance indicator set by the organisation to have all catering outlets at a Food Safety Score of level 5.
- To provide expert advice on new/changes in food safety legislation and regulations e.g. Allergens, labelling.
- The training of Nursing, Catering and Non Clinical staff on the BCUHB Food Safety Management System and Food Hygiene to a level which matches their job description and employment personal specification in relation to food service.
- To provide expert advice with the prioritising of catering equipment and kitchen infrastructure to support the writing of business justification cases for the modernisation and replacement of equipment and premises in line with the BCUHB catering strategy. The business justification cases will form the case of need for requesting capital funding.
- To conduct a programme of audits and associated compliance checks on Health Board catering premises to support continuous improvement in relation to the BCUHB Food Safety Management System.
- Undertake other activities which sit within the scope of the primary authority scheme agreement has requested by the Health Board.

Food Safety Scores as of 31st March 2022

Location	Rating	Date	Status
Anglesey & Gwynedd			
Ysbyty Gwynedd	5	03/03/22	→
Ysbyty Bryn Beryl	5	13-01-20	→
Ysbyty Dolgellau	5	21/03/22	→
Ysbyty Tywyn	5	18/03/22	→
Ysbyty Alltwen	4	14-05-19	↓
Ysbyty Cefni	5	14-12-21	→
Eryri Hospital	4	17/02/22	↑
Penrhos Stanley Hospital	5	11-01-22	→
Bryn y Neuadd	5	04-02-20	→
Conwy & Denbighshire			
Ysbyty Glan Clwyd	5	02-12-21	→
Abergele Hospital	4	02-03-20	↓
Child Adolescent Unit Catering, Abergele Hospital	5	20-01-20	→
Denbigh Infirmary	5	04-11-20	↑
Llandudno Hospital	5	21/02/22	→
Colwyn Bay Hospital	5	12-09-19	↑
Ruthin Hospital	5	28-02-20	→
Wrexham & Flintshire			

Wrexham Maelor	4	10-01-22	➔
Deeside Community Hospital	5	18-02-19	↑
Mold Community Hospital	5	27-11-19	➔
Chirk Community Hospital	5	20-10-21	➔
Holywell Community Hospital	5	28/03/22	➔
Penley Hospital	5	24/02/22	➔

Key	
No Change	➔
Increase	↑
Decrease	↓

NB – All Health Board food hygiene ratings are available from the Food Standards Agency (FSA) Web-link http://ratings.food.gov.uk

Ward Kitchens

The management of Ward kitchens has been a challenge over the last 12 months due to the ongoing pressures at ward level. The Health Boards Catering Departments have been undertaking regular audits to ensure compliance in line with the Food Safety Act.

The Infection Prevention team have taken a number of interventions to ensure compliance, which has supported best practice and improvement in the management of ward fridges.

Recent Environmental Health Officer, Food Safety enforcement visits have recognised this in the corrective action reports following the visits.

15.0 Decontamination of Medical Devices

Decontamination involves pre-cleaning, leak testing (where applicable), cleaning, disinfection, sterilisation rinsing, inspection, transport and storage, and may be a combination of manual and automated processes. For decontamination to be effective, all the process stages need to be conducted correctly, with controls and monitoring in place.

The definition of a medical device is broad and includes 'all products except medicines, used in healthcare for the diagnosis, prevention, monitoring and treatment of illness or disability'. This ranges from relatively low risk to extremely high risk devices.

Medical devices and items of equipment that are used on more than one patient have the potential to transmit infection between patients. All such devices must be appropriately decontaminated between each patient to ensure the necessary decontamination requirements are met, in accordance with all current national guidance, manufacturer's instructions and Infection Prevention Team guidance to ensure optimum patient and staff safety.

The Welsh Government Welsh Health Circular (WHC/2015/050 from 2016) presented the Decontamination Improvement Plan for organisations across Wales in order to ensure that re-usable medical devices are safe for use on a patient and for staff to handle without presenting an infection risk. To provide necessary assurance of compliance with decontamination processes, six monthly decontamination audits were conducted in 2021/22 by the Decontamination Adviser and Nurse. There are several infrastructure/resource challenges, including out of date/aged automatic washer disinfectors and air handling units, which pose a significant risk if they fail; they could not be easily repaired and this would interrupt service continuity. This has been logged on the Tier 1 risk register with a score of 16.

A Welsh Government Peer visit also took place in October 2021 and concluded that the operational team within BCUHB takes medical device decontamination very seriously and the subject is at the top of the strategic priority list. It was accepted that a number of infrastructure/resource challenges have prevented progression in a number of areas. The importance of ensuring that the Integrated Medium Term Plans include strategic and operational plans for improvements to the decontamination of devices and instruments was

stressed. Furthermore, it was recommended that the focus should be Health Board wide not hospital site specific.

15.1 **Sterile Services Departments**
There are three hospital Sterile Service Departments in BCU, one on each acute site.
Each Sterile Service Department (SSD) within BCUHB is registered with the Medicines and Healthcare Products Regulatory Agency (MHRA); this is a Welsh Assembly Government mandatory requirement and to enable this registration, 'Article 12 of Directive 93/42/EEC, ISO 9001 latest versions' certification is required. Medical devices which cannot be centrally decontaminated within the SSD must either be single-use or decontaminated in accordance with manufacturers' decontamination instructions, national and infection prevention guidance, BCUHB Cleaning Responsibilities Framework and other appropriate protocols. Facilities for decontamination processes should be compliant with applicable Welsh Health Technical Memorandums (WHTM).

A critical failure occurred at the SSD at YGC in March 2022 involving a cooling coil on the Clean Room air handling plant, which ruptured resulting in water leakage throughout the Clean Room Area. Once isolated and removed, no ventilation provision was in place for the 'Clean Room' until Mechanical Parts were received, resulting in the transfer of services to WMH. During this time, a critical failure at WMH also occurred resulting a temporary stop in service, however, prompt action was taken, the issues were resolved quickly and service continued. Patient care was not affected.

All SSDs are currently under review due to their ageing infrastructure and sterilising equipment. A pan-BCUHB audit is to be conducted by NWSSP (NHS Wales Shared Services Partnership) in May 2022 to prioritise the need for up-grading by condition.

15.2 Endoscopy
The Decontamination of flexible endoscopes is undertaken at various service departments throughout BCUHB. An Annual review of each of the flexible endoscope decontamination facilities is undertaken by the Authorising Engineer for Decontamination from NWSSP to assess the suitability of decontamination facilities, determining if they are fit for purpose as part of a Joint Advisory Group (JAG) accreditation assessment. Key points from the reviews are included below. Endoscopy services are also to be included in the review being carried out by NWSSP during Quarter 1 2022/23.

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YGC: YGC Endoscopy Unit decontaminate flexible endoscope for their service and theatres.
Previous assessments from December 2020 raised considerable concerns with the built environment and the systems incorporated. In 2021/22, it was acknowledged there had been significant improvement in the operational management systems, however considerable concerns and limitations remained with regards the built environment/facility.
The report recommended the following:

- urgent consideration to be given to move decontamination to a purpose designed facility that presents a segregated environment compliant to relevant standards. A project group is to be formed to develop a more compliant solution in a projected timescale of two years.
- the Health Board place the current facility on the risk register. This has been completed.
- that an electronic track and trace system was implemented to link device usage to individual patients. This has been purchased and will be implemented in Quarter 1 of 2022/23.

WMH: WMH Endoscopy Unit decontaminate flexible endoscopes for their service and theatres. The annual review reported that the built environment where decontamination takes

place does not meet requirements of WHTM 01/06 and principles of HBN 13 and included the following points:

- the flow pathway of endoscopes and staff can be compromised as the current layout presents the potential for inadvertent errors managing clean/dirty scopes. There is a clear procedure in place to outline the process required and mitigate the risk. Discussions are underway to look at options for moving the service to another site and to include the decontamination of nasendoscopes and urology's cystoscopes.
- the area is cramped and congested with concerns identified with the functionality of the decontamination area. There is a clear procedure in place to outline the process required and mitigate the risk and discussions are underway to look at options for moving the service to another site as outlined above.
- a dedicated electronic trace-ability system should be installed to record all stages of the decontamination life cycle. Funding options for this are being explored.
- the ventilation directly serving the Unit should be inspected quarterly and verified annually to include air change rates, pressure differential between clean/dirty areas of endoscopy area and system balance. This will be included in the review by NWSSP in June 2022.
- a formal permit to work system should be implemented for work activities that are carried out on ancillary services supplying the facility. Estates now have robust Permit to work process in place.
- a Health and Safety representative from within BCUHB reviews the management of chemicals required for decontamination of endoscopes within the facility. This has been completed.

YG: YG Endoscopy is responsible for the decontamination of all flexible endoscopes with the exception of the ENT Service, which is currently under review. The plan involves acquiring an additional AER (Automated Endoscope Reprocessor) to fully centralise the decontamination of all endoscopes which will achieve a "Gold Standard" for YG. It is anticipated that YG Endoscopy will achieve their JAG (Joint Advisory Group) Standards Accreditation for endoscopy in autumn 2022.

15.3 Other scopes and probes

- **Choledochoscopes**: these are currently only disinfected via an AER, options to sterilise them in line with the latest guidance are to be explored in 2022/23.
- **Trans-oesophageal echocardiogram (TOE) probes:** these are currently decontaminated using a disinfectant immersion bath system which is no longer supported by the supplier. Alternative methods to decontaminate TOE probes will be explored in 2022/23.
- **ENT Nasoendoscopes:** The washer disinfectors for nasoendoscopes were de-commissioned in March 2022 as they were at end of life and no longer compatible with available safe disinfectants. A three-step manual wipe decontamination process is in place to maintain services in the short-term, and longer-term options are being explored during 2022/23, and include the use of single use nasendoscopes.

15.4 Ophthalmology

Decontamination standards related to laser contact lens are being updated at all three Ophthalmology Services in YG, Abergele and WMH to ensure standardisation across BCUHB. The air-handling unit at YG day unit is also nearing end of life and will require replacement in the near future.

15.5 Ultrasound equipment

During 2021, it was reported that ultrasound gel had been associated with outbreaks of infection in various settings worldwide. Standard ultrasound gel is not a sterile product, although sterile versions are available. Examinations using ultrasound and ultrasound-guided invasive procedures are conducted routinely in various clinical settings and situations in BCUHB.

To ensure safe use of ultrasound gel to reduce risk of transmission of infection arising from these products, the Decontamination Advisor conducted a BCUHB wide audit of all ultrasound machines and their use of gel including acute and community settings.

Overall standards were high and in line with the latest guidance. One area at YGC was found to be decanting gel from one container to another, however, this was rectified immediately and practice aligned with guidance.

Medical Physics and Medical Engineering have a new dedicated team working with Radiology, Sonography, the Infection Prevention Team and the Decontamination Adviser creating a robust service to address any potential issues arising, which provides assurance to all stakeholders.

15.6 Community Dental Services (CDS)

In total, the CDS has 27 community clinics with provision for 56 dental surgeries; located across Community Hospitals, Health Centres and one Prison (a two-surgery clinic located within HMP Berwyn, Wrexham). Three static mobile units are also used as temporary replacement clinics located at Bangor and Pwllheli. In addition to the above, the CDS operates general anaesthetic (GA) services from the three acute sites and Llandudno General Hospital. Dental clinics offer a range of services dependent upon variables such as team skill mix, equipment and the physical constraints of buildings. These range from core CDS dental services including extractions, fillings and dentures, to more specialised services including Intravenous Sedation, Inhalation Sedation, GA assessments, Intermediate Tier Oral Surgery Treatment, bariatric chairs and Wheelchair recliners. The CDS also has a training commitment for undergraduate and postgraduate dentists hosted at a several sites.

Currently the service has a fleet of nine Mobile Dental Units, a mix of drivable and towable units, which are used for a variety of purposes, including:

- Oral health examinations and treatment at schools, care homes and other sites.
- Temporary substitution for clinics at or near sites that have been closed or are being upgraded.

Significant improvements to clinic facilities achieved over recent years include: Caia Park Wrexham, Buckley, Blaenau Ffestiniog, Flint and Corwen Dental Clinics relocated from outdated accommodation to modern purpose designed and built facilities.

The modernisation of Royal Alexandra Hospital, incorporating merger with Prestatyn and Aberegle clinics, is anticipated as being completed within the next two to three years (subject to WG Business Case approval).

In contrast, several CDS dental clinics still operate within unsatisfactory or outdated accommodation. Bangor and Pwllheli CDS clinical premises are of particular concern. Following the closure of buildings in 2012 and 2016 respectively, dental services were relocated to static mobile units on a temporary basis. CDS patients at Bangor clinic have been accommodated within this ‘temporary’ arrangement for several years. Urgent

progress needs to be made and the CDS remains committed to bring all dental clinics up to appropriate modern standards within an acceptable timeframe. The lack of progress for both of these schemes has been highlighted on the risk register.

16.0 Antimicrobial Resistance and Prescribing Programme

Antibiotic stewardship (AMS) is key in tacking antimicrobial resistance (AMR). Without good stewardship, many procedures and interventions would simply not be possible as the prophylactic and treatment antibiotics will not be effective. In some cases, we are beginning to reach that threshold.

16.1 Compliance with Welsh Health Circular AMR Improvement Goals 2021/22

BCUHB at the end of the year is on target with all the measurable improvement goals set by the Welsh Government.

Improvement Goal	Compliance
Goal 1: To achieve a minimum 25% reduction in antimicrobial usage in the community from the 2013/14 baseline.	BCUHB has achieved end of year position: the current cumulative position against the baseline is a total antimicrobial prescribing reduction of 38.6%.
Goal 2: Prescribers should document the indication and appropriate read code for all antimicrobial prescriptions.	This has been widely communicated however, there are no metrics available to monitor this.
Goal 3: Primary care clusters should ensure urgent dental cases should be seen by dental services rather than General Medical Services.	BCUHB position not to prescribe has already been issued and adhered to. Prescribing for dental is monitored at practice level. See below for the detail on work with dental services.
Goal 4: Increase to or maintain the proportion of antibiotic usage within the WHO Access category to ≥55% of total antibiotic consumption (as DDD).	BCUHB has achieved end of year position: all acute hospitals are prescribing access category drugs with a proportion greater than the target of 55%. See graph below: figure 3.
Goal 5: All Health Boards and Velindre NHS Trust will implement the principles of 'Start Smart then Focus'.	This has been implemented as a Tier2 audit in Health Board, under the leadership of the office of the medical director. Compliance is currently poor but there is work ongoing to improve the position and compliance.

16.2 Antibiotic Resistance

PHW have published the annual summary of antibiotic resistance (AMR) for all hospitals in Wales results from 2020. Data is taken from the microbiology system from all samples received.

The report states that there is variation between hospitals with some concerning resistance rates to certain commonly used antibiotics to certain bacteria, including those in BCUHB. There are concerns around antimicrobial resistance particularly with some broad spectrum antibiotics.

Summary of % resistance rates for BCUHB and acute hospitals in BCUHB for *E.coli* in bloodstream infections is shown below:

E.coli	co-amoxiclav	PTX	Gent	PTZ/Gent	3GC	Amikacin	Co-trimoxazole	Fluroquinolones	carbapenem
BCU	51.3	23.5	15.8	23.6	15.9	n/a	42.6	23.7	0
YWM	50.3	33.5	21.3	33.8	20.5	5	43.5	28.6	0
YGC	54.4	18.9	11.4	18.9	15.2	2.4	44.8	18.4	0
YG	48	16.8	14.5	16.9	12.4	1.6	40.5	25.5	0

Red indicates highest rates in Wales, amber second highest in Wales.

Key:
PTX – Piperacillin/tazobactam, gent – gentamicin, 3GC – 3rd generation cephalosporins
YWM – Ysbyty Wrexham Maelor, YGC – Ysbyty Glan Clwyd, YG – Ysbyty Gwynedd

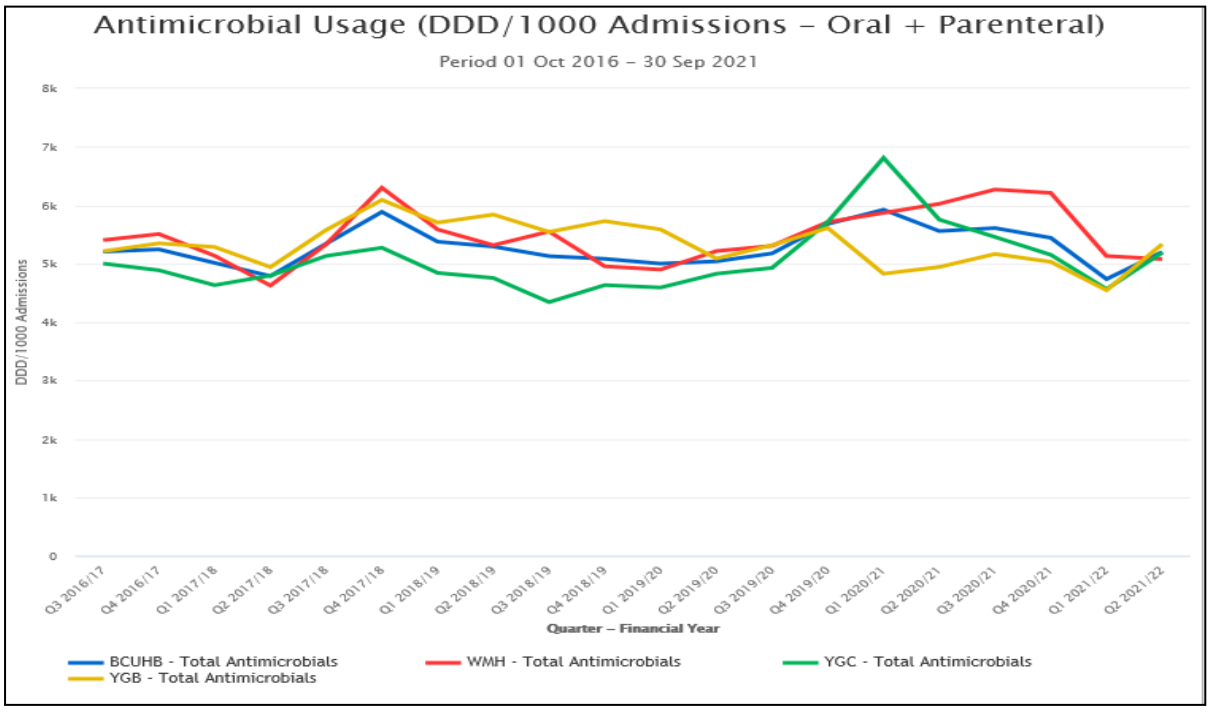
For Co-amoxiclav, both Ysbyty Glan Clwyd (YGC) and Wrexham Maelor (YWM) are highlighted as having co-amoxiclav resistance greater than 50%.
YWM has the highest rate in Wales for gentamicin resistance and the second highest in Wales for 3rd generation cephalosporins.
Fluoroquinolone resistance for YG and YWM is highlighted as being greater than the all Wales average.

To address this issue and further antibiotic resistance complications, a Resistance Group has been established to provide timely and detailed patterns of resistance to support work and allow targeted intervention. The group is chaired by a Consultant Microbiologist and has strong epidemiology and informatics support. Work has also began with the Sepsis Triggers Escalation and Antibiotic Stewardship Review (STEAR) group (see below) due to the nature of many of the antibiotics used now having AMR issues.

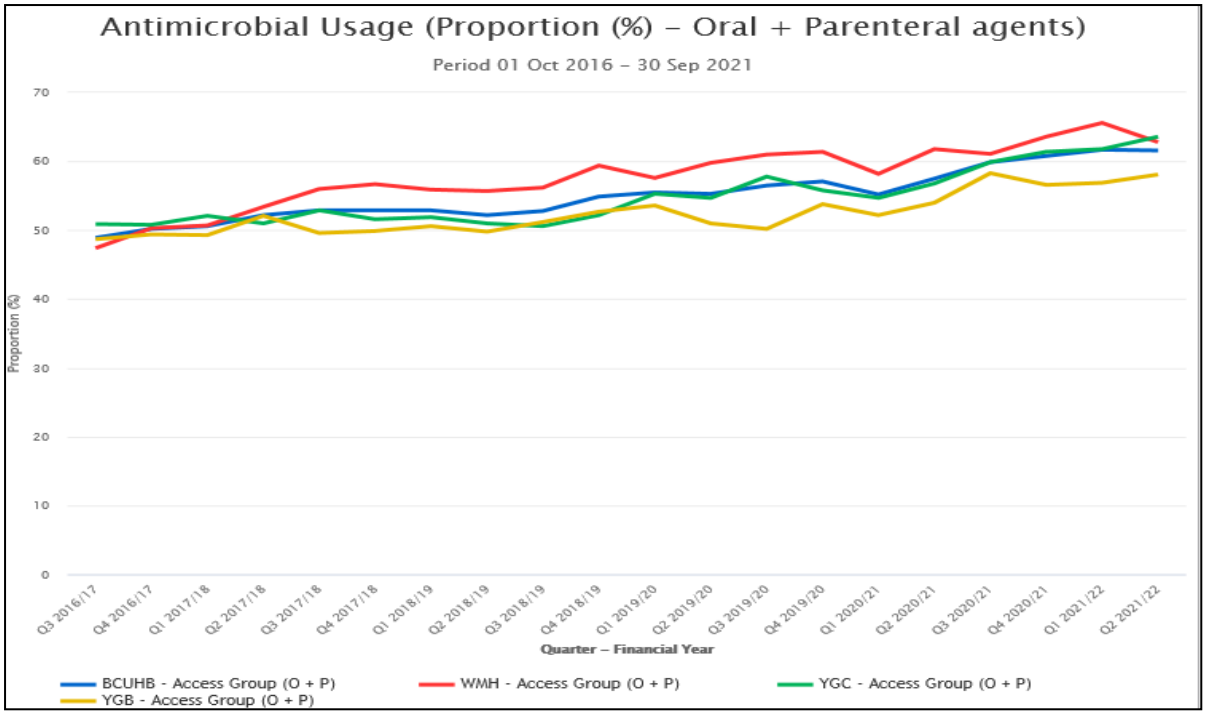
16.3 Secondary Care Prescribing
All hospitals in BCUHB have seen improvements in prescribing; however, with the background of increasing resistance, more work is needed in this area. Data is limited, as all hospitals in Wales have moved over to the new electronic dispensing system Wellsky and this has caused data issues at PHW.

Successful collaboration with the Biochemistry Team has been undertaken and resulted in the implementation on changes in reagents used for testing high risk antibiotic levels. Further collaboration is expected as the Biochemistry Team introduce new analysers and high risk antibiotic level testing to bring in house.

PHW data Antimicrobial usage DDD/1000 Admissions is illustrated below



PHW data % proportion of antibiotic usage within the WHO Access category as of total antibiotic consumption is shown below:



16.4 STEAR Group: Sepsis Triggers Escalation and Antibiotic Stewardship Review Group

This group was established to review sepsis management, update sepsis tools and ensure that all BCUHB patients are cared for appropriately in relation to sepsis. The team is reviewing the tools used for the identification and management of sepsis in line with the latest evidence. This is to support the AMS work in reducing AMR, only using antibiotics when appropriate and using the correct antibiotics at that time.

16.5 AMR International Work

In November 2021, a Malawi/Wales antimicrobial pharmacy partnership was established. BCUHB was the NHS host in Wales led by the Consultant Antimicrobial Pharmacist. The partnership was awarded the Commonwealth Partnerships for Antimicrobial Stewardship (known as CwPAMS) grant from Fleming Fund grants programme (UK government fund to tackle AMR worldwide). The grants and partnerships are managed by Tropical Health and Education Trust and Commonwealth Pharmacists Association. BCUHB were awarded £20,000 to establish a partnership and develop and run an AMS programme in Malawi. This project has carried out the Global Point Prevalence Study (the first in Malawi), developed a training toolkit and is running 'train the trainer' session in Malawi for pharmacy team members in AMS. This work has enabled shared learning to develop wider AMS skills to benefit the patients of BCU and Malawi.

16.6 Dental

Work has progressed in dental to include the development of a prescribing database, AMS audit and an antibiotic prescribing guideline. This work was started following contact from the clinical lead dentists and their concerns over AMR and the lack of AMS in their sector.

16.7 Start Smart then Focus

The audit has started as a Tier 2 audit and is being monitored by the Office of the Medical Director. Compliance still requires work, however, the outcome in quality work has allowed AMS to be focused on certain wards.

16.8 Primary care Prescribing

The pandemic has seen a shift in the way primary care functions. Remote prescribing is a concern for AMS and decrease in prescribing has been seen throughout Wales. The overall picture is that of decreases with an overall decrease to meet the improvement goal. However, as services have opened post lockdown, prescribing rates are returning to pre-pandemic levels.

Antibacterial items per 1000 STAR-PU BCU and Wales is shown below:

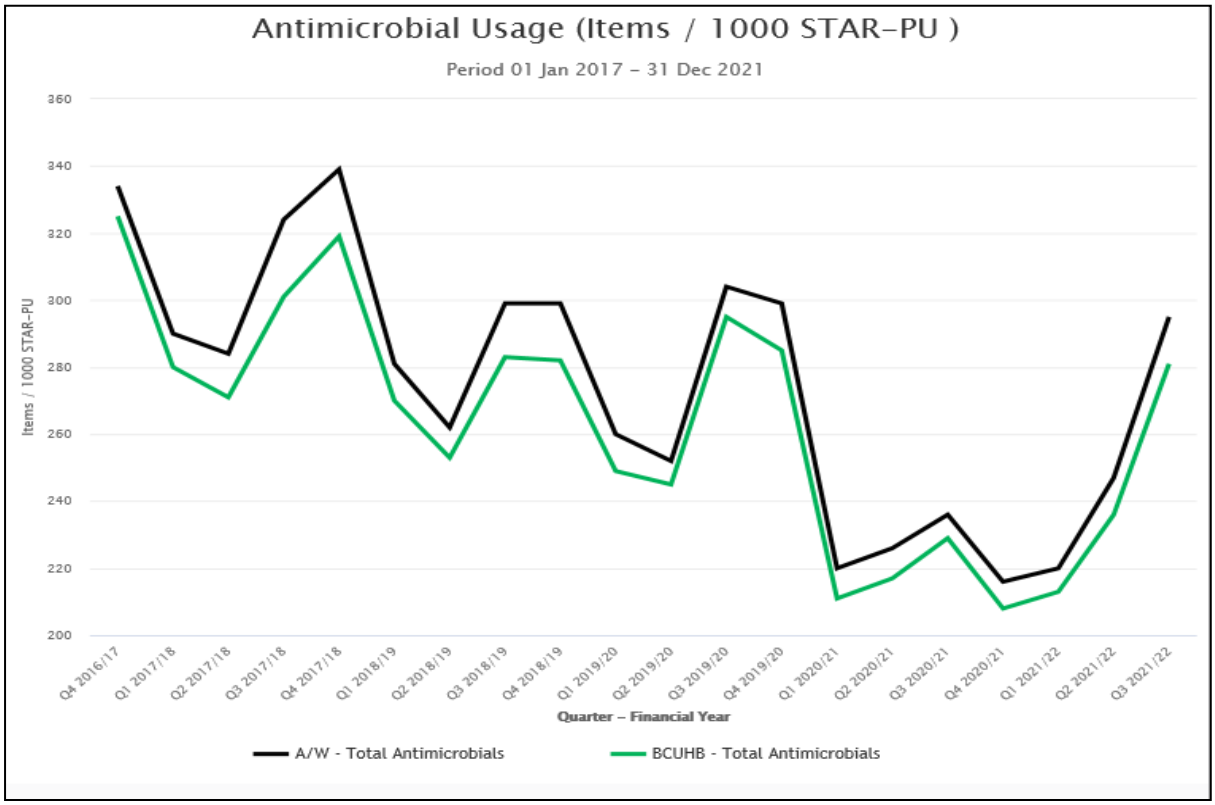
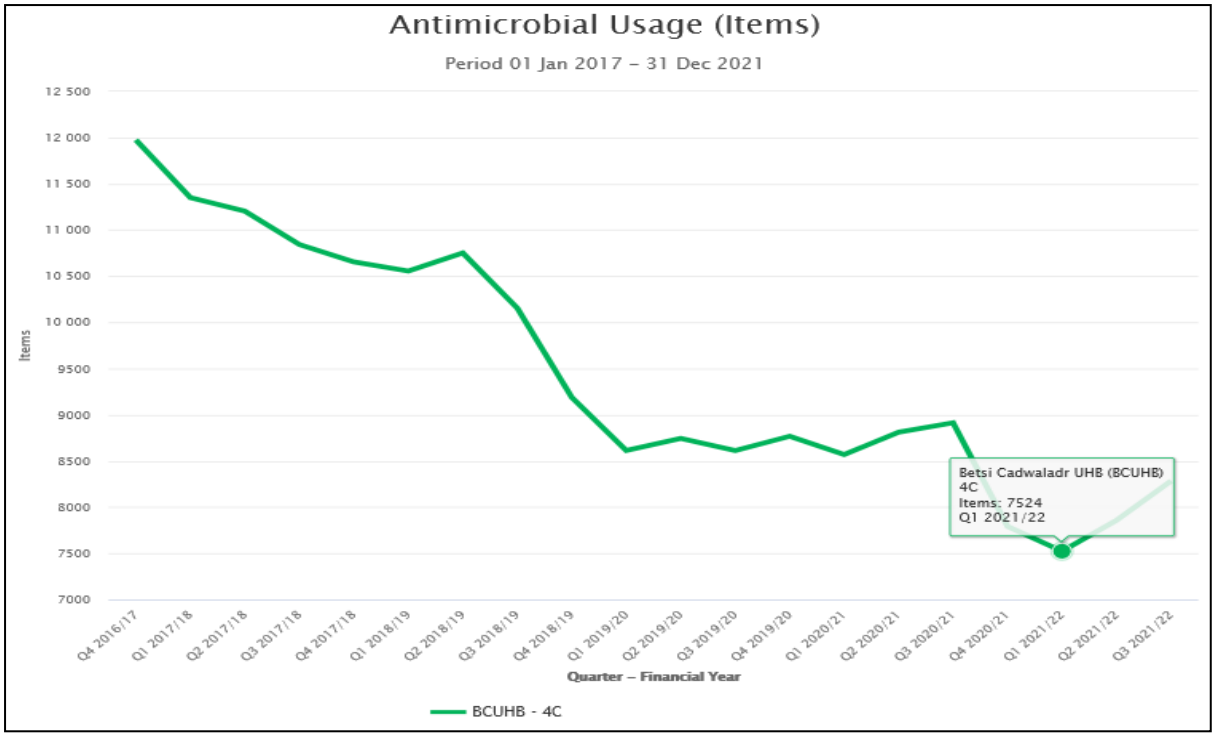


Figure 5: Total 4C Items in BCUHB



17.0 Visits by Healthcare Inspectorate Wales (HIW)

There were two visits during 2021/22 whereby infection prevention recommendations were provided by HIW, and which were promptly addressed.

17.1 Hergest Unit, Ysbyty Gwynedd, September 2021

HIW completed two unannounced mental health inspections of Ysbyty Gwynedd, Hergest Unit within BCUHB. The first occurring the evening of 6th September 2021, the second starting on the evening of 20th September 2021.

During the inspection on 6th September, HIW identified a number of areas of concern particularly around infection prevention and control, governance and leadership. Due to concerns about patient safety, HIW issued an assurance letter immediately after the inspection with their findings requiring urgent remedial action. HIW returned to undertake a further unannounced inspection commencing on 20th September to ensure the Hergest Unit was providing safe and effective care.

Overall, HIW were able to identify evidence that the Health Board had started to implement systems and processes to address the areas identified in the immediate assurance letter issued, however, further improvements were required. These included:

- The Health Board must ensure that all staff check visitor's compliance with COVID-19 procedures.
- The Health Board must ensure that the isolation suite has suitable storage for PPE.
- The Health Board must ensure that HIW are provided with details of improvements made to the isolation suite.

17.2 Tan Y Coed, Bryn Y Neuadd Inspection 19th October 2021

HIW undertook an unannounced inspection of Tan y Coed on 19-20 October 2021. Tan y Coed provides a rehabilitation service for people with learning disabilities. HIW found evidence that overall the service provided a positive patient experience, with a good level of safe and effective care delivered to patients. HIW found evidence of a well-established management team supported by a committed workforce and sound local governance arrangements. The inspection identified a small number of improvements to strengthen the service model and promote a quality patient experience.

The area of concern related to infection prevention was that the Health Board must ensure that the cleaning schedules have been completed fully, including reasons why areas may not have been cleaned.

18.0 Health and Safety

18.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

A total of 24 COVID-19 related RIDDOR reports were made to the Health and Safety Executive in 2021/22 in comparison with 752 in 20/21.

18.2 Mask Fit testing

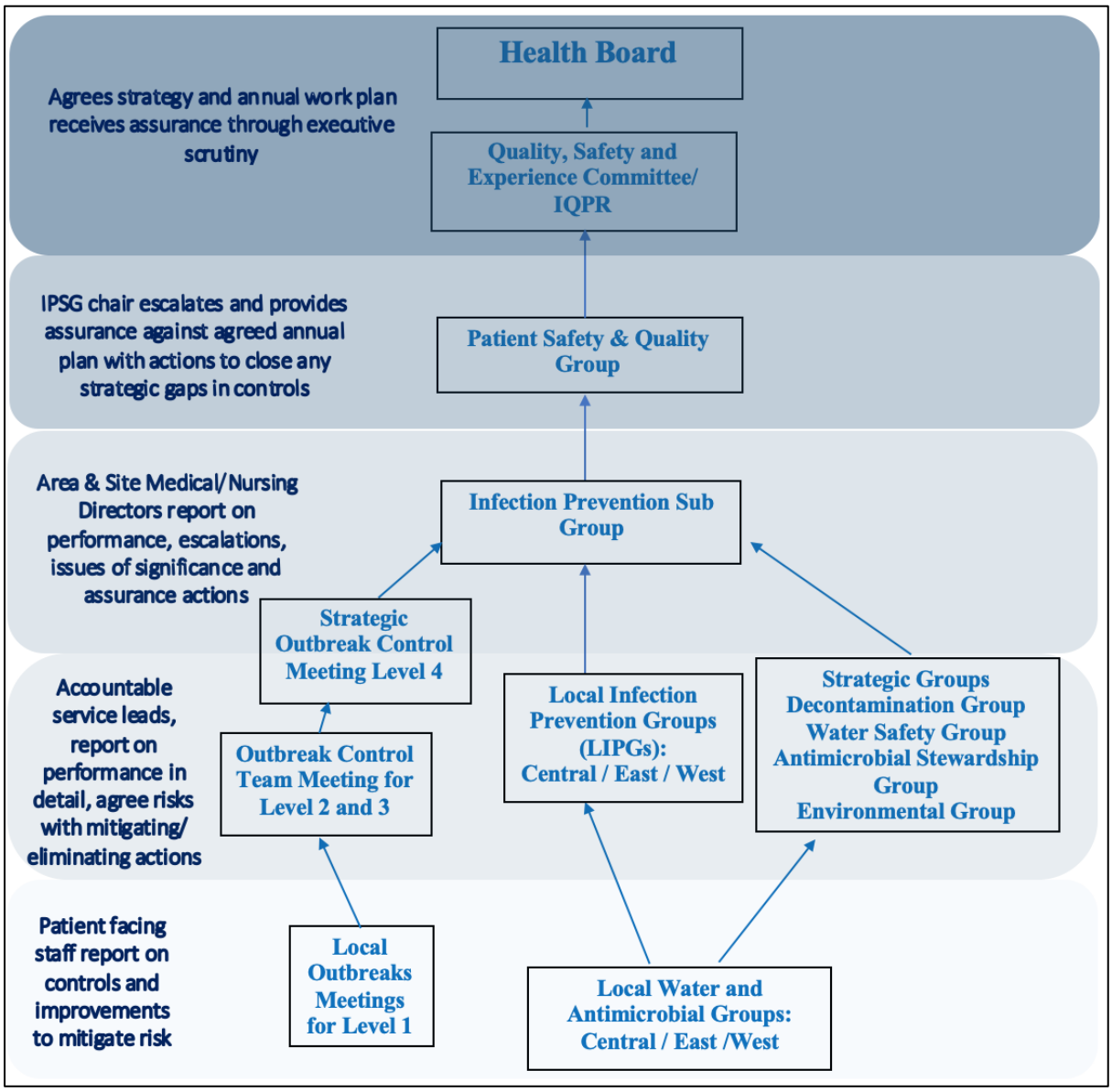
In 2021/22, 6325 FFP3 fit tests were undertaken on healthcare workers across BCUHB. A full local reporting database is now operational of all staff within their wards and departments who require fit testing. Individuals that are not required to be fit tested have the reason recorded e.g. maternity leave or long term sick, to ensure they are captured during regular checks by managers on compliance within their area.

Once fit testing has been completed, the staff member is provided with a certificate giving full details of the mask type, model, size and expiry date where applicable.
BCUHB have 24 Porta Count Qualitative Testing machines and all fit testers have been trained by Fit2Fit Accredited Trainers.

Fit tests are now a mandatory training compliance on ESR for all staff and this is updated via a report distributed each week by the fit testing co-ordinators.

19.0 Appendices

Appendix 1: An organogram of the accountability arrangements of the Infection Prevention Sub Group



Appendix 2: Key Infection Prevention and Control Risks

	Risk Description	Mitigation and Progress	Initial Score	Current Score
1	Potential that medical devices are not decontaminated effectively so patients may be harmed: There is a risk that medical equipment will not be decontaminated appropriately. This is caused by a number of factors including: 1. Sterile service departments air handling units	1. Decontamination audits have been increased to twice yearly. 2. A capital replacement programme is used to address aged sterilising equipment in Sterile Services and Disinfection Units. 3. The Decontamination group has been re-established following the latest COVID peak to ensure monitoring, progress and learning.	16	16

	require upgrade/replacement, some equipment and the track and trace system requires replacement and at WM hospital the steam generation plant and electrical infrastructure requires an upgrade. 2. Poor, outdated facilities for decontaminating dental equipment, scopes and probes and washer disinfectors at YGC and WM are at end of life. Also they rely on a paper track and trace system. 3. There is a lack of robust approved SOPs for decontamination. This could lead to transmission of infection, vital treatments and services having to stop, patient complaints and litigation, enforcement action, improvement notices, multiple breaches in statutory duty, critical reports and adverse media coverage.	4. Disseminating good practice from the new Endoscopy Unit at Ysbyty Gwynedd to other Units across the Health Board. 5. Single use scopes are being used where possible removing the requirement for decontamination. 6. Engineering support is presented from the in-house facilities team and is generally to a high standard. 7. Governance systems are managed by the Authorised Persons (Decontamination). 8. The Executive Director for Infection Prevention has been alerted and requested an overall risk assessment. 9. There is good support from Authorised Engineer in Decontamination from NHS Wales Shared Services Partnership. **Progress:** 1. Controls in place reviewed and strengthened to align with current risk position. 2. Gaps in controls reviewed and updated to align with current risk position. 3. Agencies have been contacted for a Decontamination Specialist advisor to work for BCU for minimum of 3 months. However, due to no suitable candidates, internal team member currently acting up to the role. 4. Single use scope representative has attended all acute sites to update Consultants on the latest technology available. 5. Request made to Shares Services to carry out a review of the decontamination infrastructure to identify any priority areas. Anticipated review by July 2022. 6. Action ID 23024 - New action identified to seek Joint Advisor Group on Gastrointestinal Endoscopy accreditation 2022 at Ysbyty Gwynedd.		
2	Inability to deliver timely Infection Prevention & Control services due to limited capacity: There is a risk that Infection Prevention (IP) will not be able to provide an effective service to BCUHB. This may be caused by the relative limitations in size of the service (taking the size of the Health Board into account) and the current significant unfilled vacancies. This could lead to an increase in healthcare associated infections, patient harm and	1. Infection Prevention policies and procedures in place to ensure best practice and standardisation, monitored by Infection Prevention Sub Group. 2. Senior members of the Infection Prevention team (IP) are providing support to other areas as well as their own. 3. Reviewing and prioritising the programme of work and workloads for all staff in the team e.g. ensuring experienced IP nurses are not doing admin tasks. 4. Prioritising/focussing on areas of concern/'hot spots' which may result in less visibility in areas in which IP risk is lower.	15	15

	loss of reputation to the organisation.	5. Reviewing and prioritising attendance at meetings and on groups etc. 6. Employed senior manager via an agency to support the team in Central. 7. Supporting and protecting existing team with measures including weekly team meetings and reviews. **Progress:** 1. Controls in place reviewed and strengthened to align with current risk position 2. Gaps in controls reviewed and updated to align with current risk position. 3. Contacted international nurses - 4 have been interviewed to date and will apply for vacant posts once advertised. 4. An experienced Infection Prevention nurse known to the Director of Infection Prevention now in post from an agency part time for 6 months. 5. New SBAR completed and approval given to refresh the band 8a job description used in the past and then advertise for band 8as. 8c (and 8b) will then provide additional support to help them develop and some of their work will be picked up by the agency nurse in point 2. 6. Working wherever possible as one Infection Prevention team as opposed to three, to allow experienced Infection Prevention nurses to support remotely across the sites and increase junior staffing to increase visibility of 6s. 7. Trajectory for C. Difficile has improved over the past 6 month and the Health Board now has the lowest rate of all Health Boards across Wales.		
3	Reduction in Public Health Wales Consultant Microbiologists: There is a risk that timely advice and visibility would not be available to respond to results, patients deterioration in relation to microbiology. This is because the number of consultant microbiologists had reduced across BCUHB due to retirements, study leave and ability to recruit. This could lead to patients and staff not having expert advice in a timely manner when needed.	- Locum cover in place - Routine authorising by senior Biomedical Scientists to reduce workload on existing consultants. - Exploring other staffing options to cover roles required. - Recruitment to physicians associate posts. - Antimicrobial Pharmacist team to support appropriate use of antimicrobials. **Progress:** - New Microbiologist starting April 2022. - PH Wales looking for new ways to attract and recruit microbiologists to work in North Wales e.g. establish trainee posts in North Wales.	15	9

Appendix 3: Safe Clean Care Harm Free Project Status

	Project Status	Definition	No of projects at that stage	% of projects at that stage
	Project Near Completion	Task & Finish Group closed down, evidence of embedding and sustainability required	9	36%
	Project Live	Task & Finish Group still running, more work needed to be done	8	32%
	On Hold	Project has not progressed and is currently on hold	7	28%
	Hybrid Project	Another programme or team is responsible for its delivery	1	4%

	Task and Finish Group	Project Status
1.	**Safe Place:** The Workstream encountered a significant number of staff changes including the SRO during the first 90 days of the programme and there are still some gaps including a task and finish lead and deputy SRO.	
1.1	Clean ward/hospital	
	Covid-19 cleaning addendum/decant of areas	
	Ventilation	
1.2	Review bed spacing across BCU	
1.3	Safe entry	
	One way system and signage	
	Reduced number of entrances to sites, and compliance with Infection Prevention Control (IPC) guidance upon entry to hospital	
	Lateral flow testing for patients coming in for face to face appointments	
	Reduced number of admin staff on site	
1.4	Safe break	
1.5	Safe change	
2.	**Safe Space**	
2.1	Safe front door	
	Unscheduled care segregation/isolation/safe transfer to inpatient ward	
	Results management	
2.2	Safe access	
	Safe access to clinical areas	
2.3	Safe wards	
	Routine inpatient COVID-19 testing	

	Virtual ward rounds	
	Board rounds	
2.4	Safe transfer	
	Rapid isolation of newly suspected IP risk patients	
3.	**Safe Action**	
3.1	Visibility of leadership	
3.2	Patient walking with purpose	
3.3	Infection prevention policies and procedures	
	Review of infection prevention policies and procedures	
	Infection prevention champions	
3.4	PPE: Donning & doffing	
3.5	Patient discharge & transfer	
3.6	Safe visitor	
	Inpatient visitor guidance	
	Inpatient visiting lateral flow testing	
3.7	Catheter acquired urinary tract infections (CAUTI)	

OUR VISION

Zero healthcare associated infections (HCAIs)

Infection Prevention Sub-Group – Plan on a page

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

OUR PRIORITIES FOR 2022-2023

Lower the burden of infection	Reduce IP risk from medical devices	Optimise antimicrobial use	Improve education and training in IP	Lower the environmental burden

A COLLABORATIVE APPROACH TO DELIVERING OUR PRIORITIES

Staff engagement & ownership across all staff groups. Standard precautions for all. Patient & outbreak reviews (PIRs). Audit & surveillance programmes. Vaccination campaigns. Data & epidemiology. Optimised use of sidercoms. Policies and protocols. Effective outbreak control meetings.	Risk management. Improvement plans. Capital investment. Policies and protocols. Audit and surveillance. Education and training. Sharps management. Management beds and mattresses.	Prudent prescribing. Resistance data. Audit and surveillance. Staff engagement. Policies and protocols. Antimicrobial ward rounds. Education and training including primary care.	Staff qualified in IP for their role. SCC-HF improvement initiatives. Share lessons learnt & good practice. Develop IP Champions. Promote MOOC. Mandatory training. Patient/carer/visitor education. Policies and protocols.	Credits for cleaning (C4C) audits. Cleaning protocols. Deep clean programmes. Ventilation maximised. Safe Water, incl water sampling & little-used sinks. Improvements to the estate. Risk management. Food safety. Environmental risk assessments.

TARGET

Monitor comparative & trend data. Business case for future IP team. Increase medical engagement with IP. Develop IT for monitoring & reporting. Review of CDT in cancer patients. Complete study of ward-level predictors of COVID-19 outbreaks. Quarterly deep dives at IPSG. Effective use and feedback of data.	Develop an inclusive risk register. Develop decontamination strategy. Complete CAUTI project work. Improve compliance with blood culture & vascular bundles. Complete twice yearly decontamination audits. Promote catheterisation e-learning programme.	Antimicrobial workplan. Refine and launch antimicrobial dashboard. Develop protocol for CPE. Revise restriction policy. Strengthen SSIF audit. Implement mandatory AMR training. Improve primary /secondary care info exchange	Bimonthly IP newsletter & IP Conference. Review and refine PIR processes. Establish IP Champions on every shift. ANTT assessors in every ward/dept. Improve mandatory training rates. Review & update patient/carer information. Promote IP in community & nursing homes. Support SCC-HF improvement initiatives based on key themes learnt from PIRs.	Restart Environmental cleanliness group. Complete Deep clean programmes. Drive improvements and expenditure on priorities identified at LIPGs. Ensure compliance with food safety audits. Review use of mobile air purifiers. Roll out use of Hypochlorus acid. Improve waste segregation.

SUCCESS LOOKS LIKE

No avoidable HCAIs. HCAI improvement goals achieved. Low surgical site infection rates. Vaccination targets met. Good compliance with audits.	All policies and protocols up to date and all staff aware of them. Good compliance with audits. Improved decontamination facilities. No decontamination incidents. Reduction in sharps incidents.	Improved compliance with Welsh AMR improvement goals. Reduced resistance rates. Up to date Microguide. Good compliance with audits.	ESR training compliance rates >85%. More staff qualified in IP. Patients informed and aware of how they can contribute to IP / self-care. All policies and protocols up to date.	Improved C4C scores. Low vacancy rate. Improved water and ventilation scores in annual report from Shared Services. Good compliance with audits and tests. 5 star food ratings.

REDUCTION IN ALL HEALTHCARE ASSOCIATED INFECTIONS

V3 Updated 30 June 22

Appendix 5: Safe Clean Care – Harm Free Annual Report

See separate report

Safe Clean Care – Harm Free (SCC-HF) Annual Report – 2021/22

Contents

Introduction

In 2018 the Health Board implemented a Safe Clean Care strategy to strengthen infection prevention leadership and assurance. In 2021 as part of the Health Board response to the Covid-19 pandemic, including concerns regarding other nosocomial transmission across BCUHB and related factors the original philosophy was amended and strengthened to include a range of new priorities and re-branded as Safe Clean Care – Harm Free (SCC-HF). Its aim is to have a zero-tolerance approach to Health Care Associated Infections (Nosocomial) and thus a large-scale change programme of activities aimed at sustainable changes in BCUHB's staff belief and behaviour, was initiated.

Supporting the Health Board's approach of 'Stronger Together', SCC-HF utilises the behavioural science methodology defined as COM-B (Capability, Opportunity, Motivation and Behaviour) with specialist advice and support in applying this technique provided by Public Health Wales (PHW) and their behavioural science unit.

Programme governance is provided through a dedicated SCC-HF Steering Group under the leadership of the Deputy Chief Executive / Executive Director of Nursing and Midwifery. Steering Group membership includes very senior level staff from across the entire Health Board, reflecting the priority the Board is taking around this key programme delivery. The programme outcomes, risks and deliverables are reported to the Infection Prevention Safety Group (IPSG).

From March 2021, the SCC-HF programme ran through a series of 90 day improvement cycles based on the learning of Healthcare Associated Infections (HCAI) through a number of workstream themes focusing on key deliverables. During each cycle, project activities either initiated or on hold (due to a number of reasons) were reviewed, on their maturity, key performance indicators (KPI's), outcomes to date and potential sustainability. These project reviews were undertaken to capture project performance, challenges faced and lessons learned. Whilst recognising the improvements made during the SCC-HF programme, further improvements are required to meet the overall aim and objectives within the organisation.

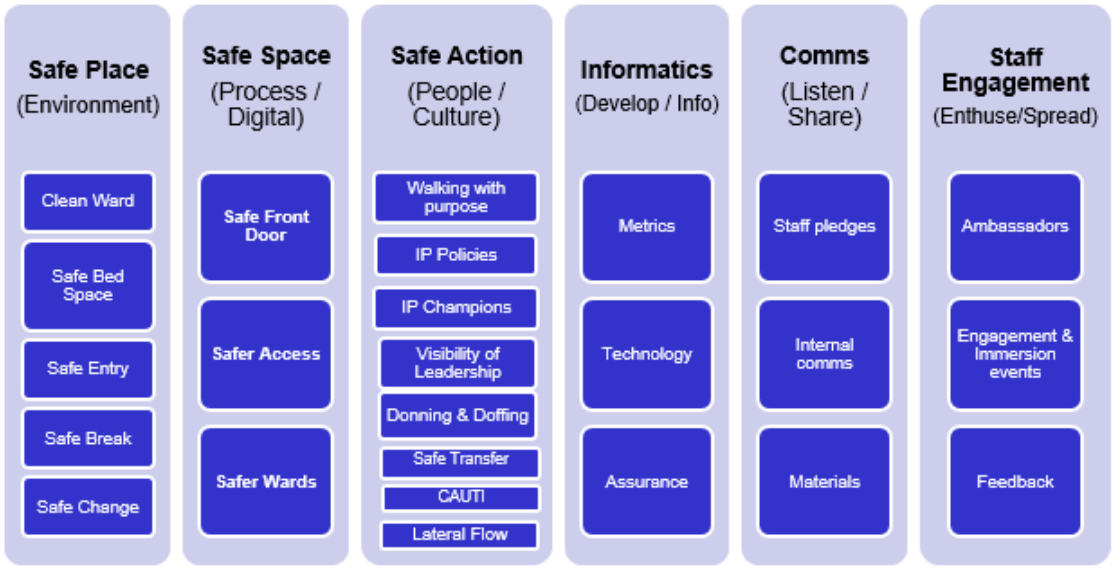
The programme was structured to fully reflect standard project management principles through a number of front line delivery and enabling workstreams, these were identified as,

- Safe Place (Environment)
- Safe Space (Process / Digital)
- Safe Action (People / Culture)

and supported by;

- Communications & Staff Engagement
- Informatics
- Patient Safety & Experience

Safe Clean Care - Harm free Workstreams



Each frontline delivery workstream consisted of a number of projects grouped into themes. Task and Finish groups were established to progress each of the projects.

Each workstream was led by a Senior Responsible Officer (SRO) and supported by a limited number of specialist Programme Managers and Service Improvement expertise. Each workstream had its own PRAID (Plan, Risks, Actions, Issues and Decisions) log and highlight reports were completed weekly during the programme initiation phase to provide continuous progress feedback to the steering group.

The workstreams were developed as a result of learning to date from Covid-19 Healthcare Associated Infections (HCAI) which sits alongside the learning from all our nosocomial post infection reviews shaping the behavioural change which is needed across the health board to deliver SCC-HF. They focused on reducing the intention to action gap, as no one comes to work to do harm and putting a supportive system in place to quickly identify risk and mitigation to ensure harm does not happen.

The gaps in infection prevention controls were:

- Learning from past infection transmissions (PIRs)
- Accountable areas 2021/22 Infection prevention plans
- 40 point HARMs Self-Assessment (Welsh Government IPC guidance)
- Pan BCUHB themes from the above gaps in infection prevention controls to provide an agreed implementation

The improvement mechanisms were:

- Local behavioural change programmes
- Services governance actions and improvement plans
- Divisions governance actions and improvement plans
- The above led by corporate SROs (operations, medical & nursing) with Quality Improvement and Programme Management input with local delivery leads in each accountable areas identified by Hospital /Area Management Teams.

During November and December 2021, all Workstreams undertook a review of their current activities and it was identified that each of the initial projects within the Programme currently fall within one of the following four categories;

- Project Near Completion - Task & Finish Group closed down, evidence of embedding and sustainability needed
- Project Live -Task & Finish Group still running, more work needed to be done
- On Hold - Project has not progressed and is currently on hold
- Hybrid Project – Another programme or team is responsible for its delivery

The category of each individual project can be found in **Appendix A** and will act as a programme stage boundary informing the SCC-HF steering group as to if these activities should be; stopped, continued or modified to meet the new organisational requirements within the new operating model.

Safe Place

Safe place consisted of five Task and Finish groups (T&F) relating to environment factors, namely:

- Clean Ward / Hospital,
- Safe Bed / Patient Spacing,
- Safe Entry,
- Safe Break and
- Safe Change.

The Workstream encountered a significant number of staff changes including the SRO during the first 90 days of the programme.

Clean Ward / Hospital

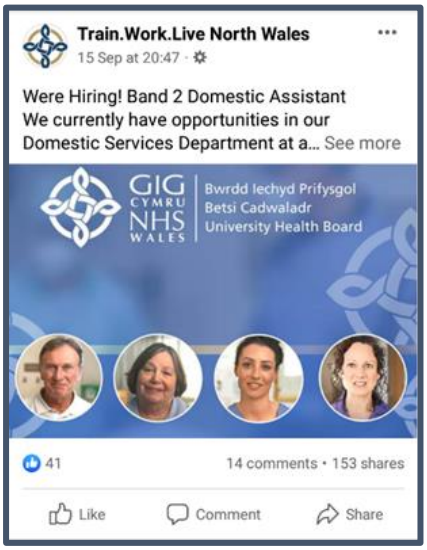
The aim was to:

- develop, assure and implement a series of guidance and recommendations to ensure safe environments and 90% compliance with Credits for Cleaning (C4C) audits by December 2021
- fully implement Covid-19 Addendum (both Pay and Non-Pay)

- undertake a review of nursing and domestic cleaning tasks

Recruitment of additional Cleaning Staff

There have been some challenges recruiting and retaining Domestic Assistants, therefore new ways of advertising vacancies and promoting the Estates & Facilities department had to be identified. A number of sessions were held with current staff to capture what it's like to be a domestic within BCUHB and the feedback was used to inform a social media campaign. The campaign started with first 'post' 18:00 on 15th October 21 and the first day 'reach' was 4,000 people with 35 shares and 205 clicks to read the link. A separate campaign was launched to target staff who may have friends or family with an interest.



It is recognised that the geography is very different across North Wales, which presents some real barriers.

Reinforcement of C4C Auditing

The National Standards for Cleaning (Wales 2009) require that continuous monitoring of environmental cleanliness is undertaken. Credits for Cleaning (C4C) is the agreed auditing tool for use in all Health Boards in Wales and is now being used in BCUHB.

The process specifies the cleanliness requirements for Health Boards in Wales and ensures continuous monitoring of environmental cleanliness across all clinical areas. Audit results are reported monthly to local and area management teams for scrutiny.

C4C provides a number of additional functions compared to the system previously used:

- Reasons why hospital areas are unable be cleaned, i.e. because there is an infection breakout etc can now be recorded on the system
- Compatibility with Internet Property Register
- Data can be downloaded and fed into internal dashboards

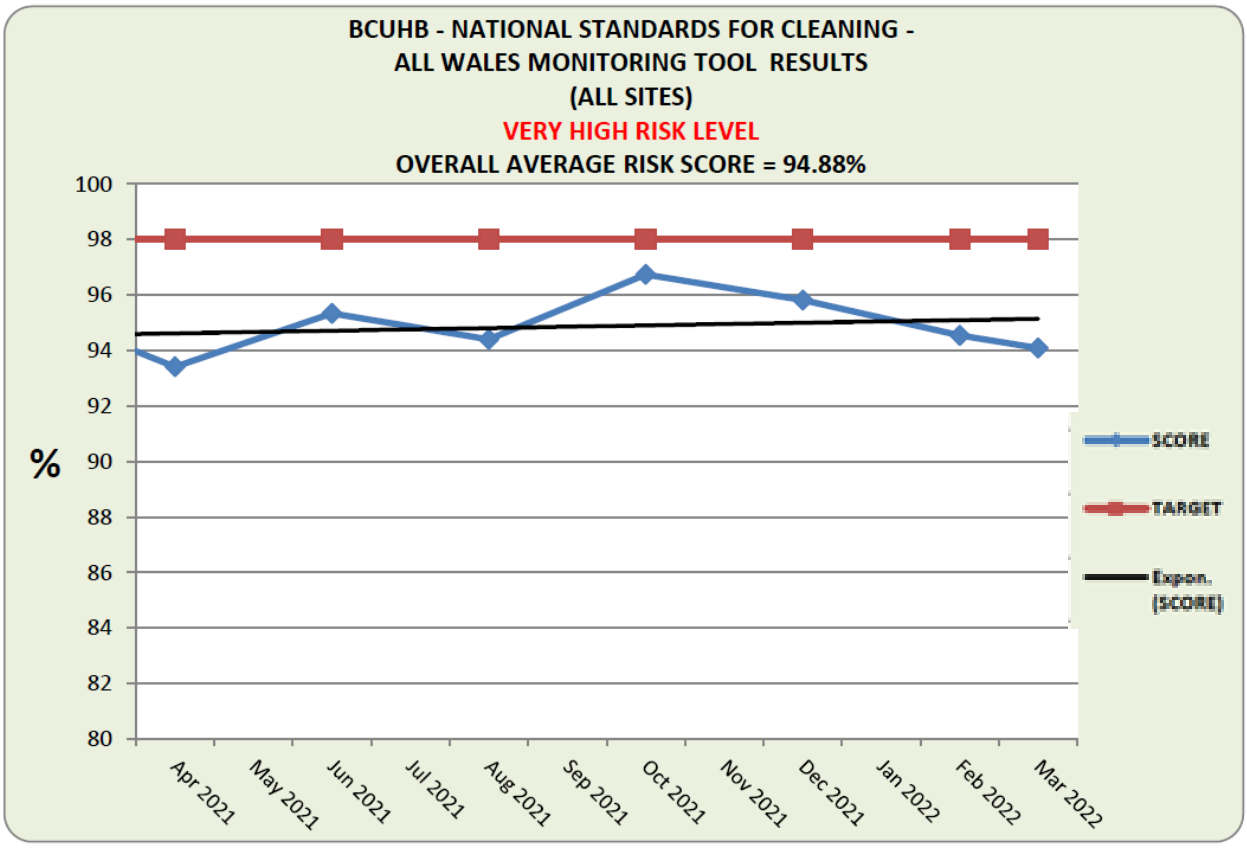
The following charts show the overall average risk scores in the 'Very High Risk' and 'High Risk' areas across BCUHB since April 2021.

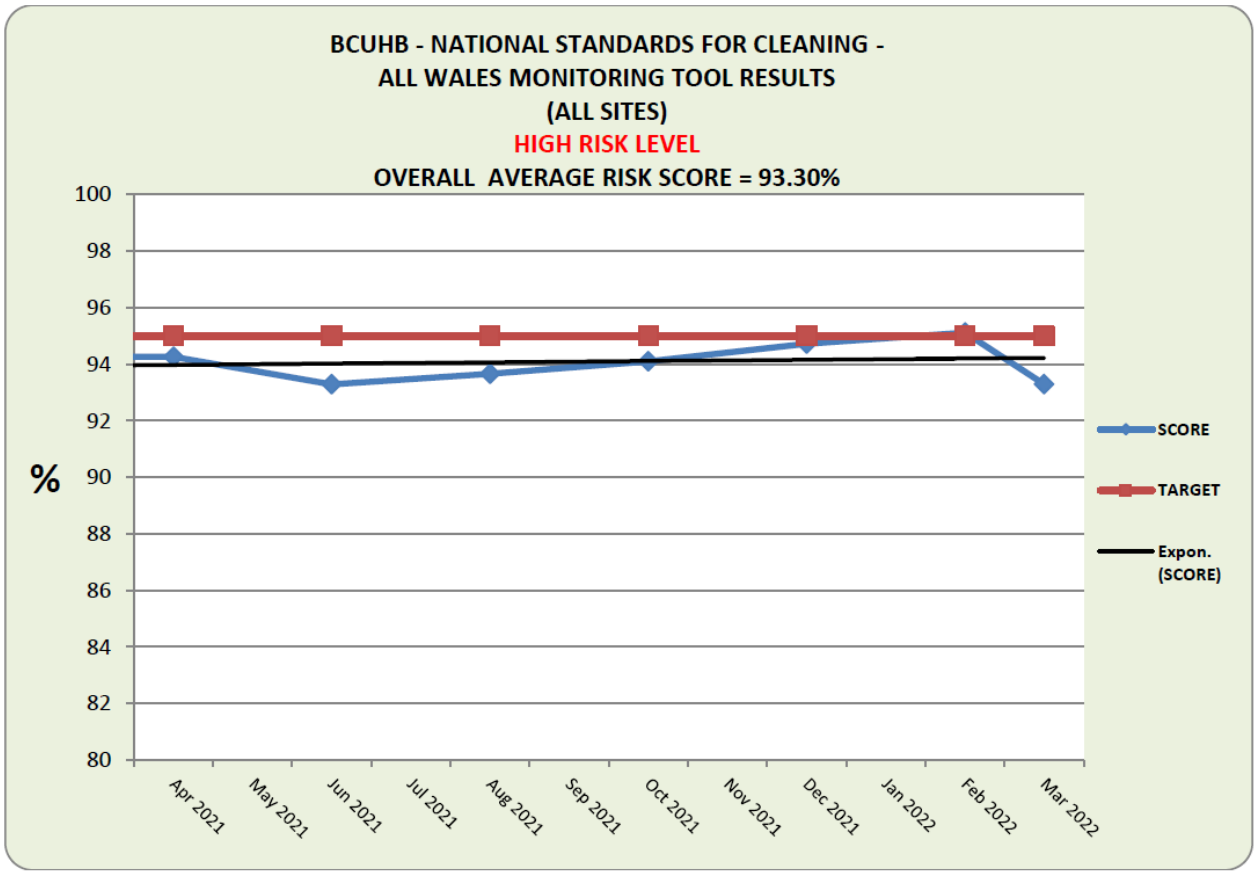
Very high risk functional areas include operating theatres, Intensive Care Units, Special Care Baby Units, Emergency departments (ED), and other departments where invasive procedures are performed or where immuno-compromised patients are receiving care.

High risk functional areas include general wards (acute, non-acute and mental health), sterile supplies, public thoroughfares and public toilets.

KEY				
Risk Level	**Minimum Target Score to achieve National Cleaning Standards for Cleaning / Nursing & Estates**	**Green**	**Amber**	**Red**
Very High	98% minimum	98% & Above	88% to 98%	Below 88%
High	95% minimum	95% & Above	85% to 95%	Below 85%
Significant	85% minimum	85% & Above	75% to 85%	Below 75%
Low	75% minimum	75% & Above	65% to 75%	Below 65%

There has been a small improvement over the year but further work is required in 2022 to reach the target.





Work escalation schedules have been implemented to address low scoring high risk areas.

New Cleaning Processes

ATP Testing

ATP (Adenosine triphosphate) testing is used to measure levels of ATP on a surface. Testing is done after a surface has been cleaned and indicates the efficiency and effectiveness of the cleaning being done and therefore the cleanliness of the environment.

CiFi Torch

The CiFi torch is an instrument that can locate human biological traces, bacteria and organic matter that cannot be seen with the naked eye and therefore supports cleaning and facility management staff to achieve forensic standard results.

Enhanced UVC cleaning

Enhanced UVC cleaning is being used in Deeside Hospital. As well as providing high levels of cleanliness it also supports the hotel services team and prevents delays in patient flow. UVC cleaning is carried out in the following areas:

- Bathrooms
- Kitchen
- Offices
- Staff rooms
- Bays
- En-suites
- Relatives Room

IPC have supported this cleaning method and Area East have also rolled this program out in Mold.

Hypochlorous Acid Misting

A trial of Hypochlorous acid misting (electrified salt and water) has shown that decontamination times can be reduced and in a shorter time than using HPV (Hydrogen Peroxide Vapour). Benefits to BCUHB are:

- A reduction in the number of beds being out of commission due to decontamination
- Improved patient flow
- Very safe to use
- A much cheaper solution than the alternatives.

The majority of training on how to use the equipment has now taken place and it is to be rolled out in 2022.

Environmental Improvements

Following the introduction of the SCC-HF programme, environmental improvements have been made that have contributed to the prevention of Health Care Associated Infections. Improvements include:

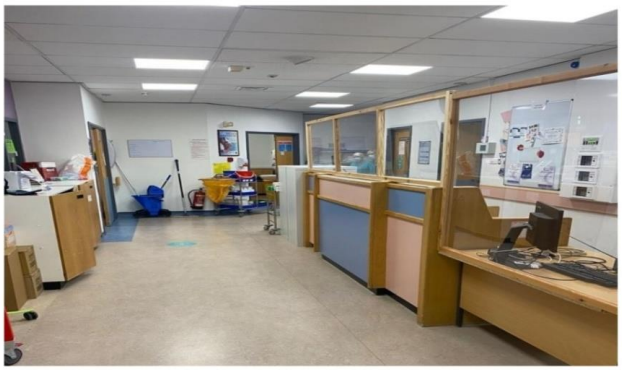
- Installation of bay doors at Ysbyty Gwynedd
- Installation of bay doors at Llandudno General Hospital
- New wash hand basins at Wrexham Maelor
- New flooring at Colwyn Bay Hospital
- Works at Glan Clwyd ED
- Clutter free clinical areas

The following photos demonstrate some environmental improvements that have been made throughout BCUHB.

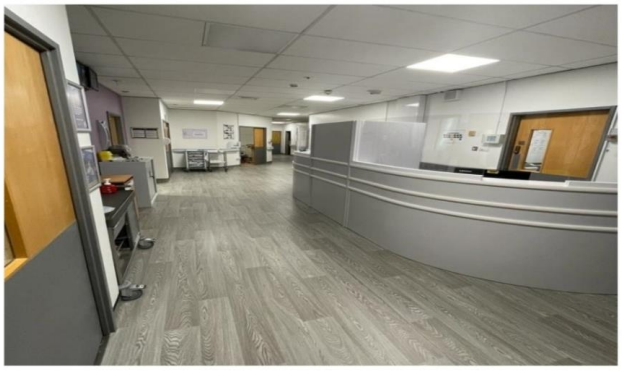
Clutter free areas at Community Dental Services in Wrexham.

Refurbishment of the maternity ward in Ysbyty Glan Clwyd

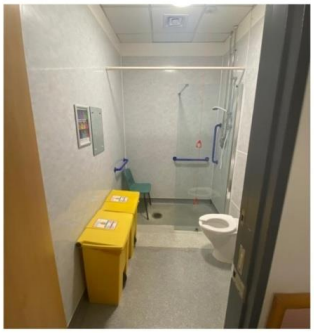
Ward area pre-refurbishment



Ward area post-refurbishment



Bathrooms pre-refurbishment



Bathrooms post-refurbishment

Bay Busters

In Area East, Matron Sylvia Morrison introduced ‘Bay Busters’ to ensure that there was a team collaborative approach to improve standards. Each bay has designated team members as the champions for that bay; this is a mixture of Health Care Support Workers, Registered Nurses and both day and night staff.

Each team are responsible for keeping their area clutter free, clean and tidy and ensuring that all information boards are up to date. Patients are encouraged not to hoard items on their tables and locker tops and families are asked not to bring excess items into hospital and to take home dirty clothing etc. in a timely manner.

Bay Busters:

Working together to ensure a safe clean environment for all

The champions work alongside the domestic team to aid weekly turnouts of the bays and the Matron and Ward Sister undertake senior walk rounds of the ward (incorporated into the environmental audits) and judge the best kept bay. That bay then gets to display a small trophy for the week and their achievement celebrated on safety huddle.

Following the introduction of 'Bay Busters', the C4C audit nursing element has improved in just one month from 84.3% to 100% and staff appear better motivated and are now taking ownership of their ward and finding their own solutions to improve our SCC-HF elements for the ward, resulting in a better environment for all.

Bay Busters is now being promoted as good practice across the Health Board and has been adopted by other wards and departments

Ventilation

The Estates department have been doing some significant pieces of work to understand the level of general ventilation within key clinical areas and wards across the health board. This excludes critical ventilation i.e theatres and major clinical areas that has an annual program of verification to ensure compliance.

Ventilation reviews have now been completed for all acute and community sites and data has been shared with Heads of Nursing and Infection Prevention regarding the need to consult with Estates when deciding upon the location of red wards and areas where Aerosol Generating Procedures are routinely carried out.

Plans for 2022/23 include:

- Ring-fencing £50k of SCC-HF funding to commence with a ventilation strategy for non-critical ventilation systems
- A review of the use of Air Purifiers with integrated UVC technology in Hebog Ward at Ysbyty Gwynedd
- Working in partnership with Clinical Teams in the Central Area to review ventilation within Community Ward Areas

Staff

Mandatory IPC Training

The following table shows the Mandatory IPC Training compliance rates for all BCUHB staff with a permanent of fixed term contract as at 28th March 2022.

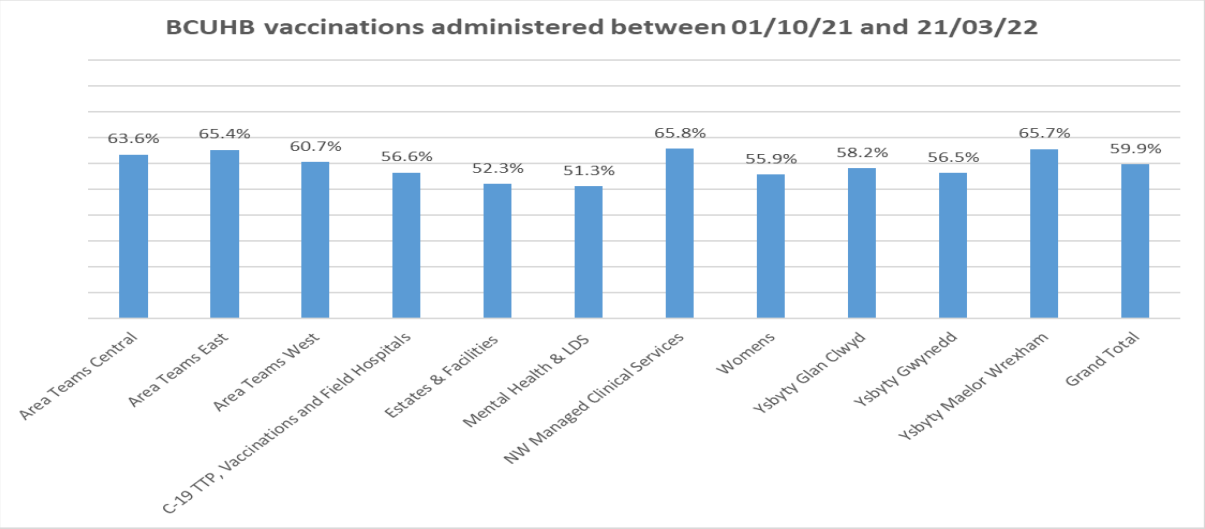
Health Economy/Pan North Wales Service	IPC - Level 1	IPC - Level 2	D&D Level 1	D&D Level 2	D&D (Removal and Disposal) Level 2
Area Teams Central	86.77%	78.67%	75.91%	73.93%	74.64%
Area Teams East	86.12%	78.95%	73.56%	71.58%	73.01%
Area Teams West	88.27%	81.63%	76.20%	71.88%	74.15%
C-19 TTP, Vaccinations and Field Hospitals	82.33%	82.52%	77.80%	83.26%	82.85%
Corporate Services	85.00%	69.96%	65.36%	68.00%	64.00%
Estates and Facilities	71.39%	35.22%	51.00%	32.17%	35.22%
Mental Health & LDS	86.62%	79.05%	74.91%	70.37%	72.34%
NW Managed Clinical Services	83.49%	75.62%	67.72%	67.57%	67.18%
Womens	80.64%	73.78%	64.99%	61.42%	63.54%
Ysbyty Glan Clwyd	80.24%	74.82%	68.32%	70.03%	70.16%
Ysbyty Gwynedd	79.68%	72.65%	65.51%	64.26%	66.08%
Ysbyty Maelor Wrexham	85.55%	77.05%	73.15%	71.45%	71.45%
Grand Total	**83.52%**	**76.61%**	**69.91%**	**69.56%**	**70.58%**

In order to improve their compliance, Estates & Facilities are working with Unison on accessing funding for digital numeracy and literacy. They have also purchased and received 40+ iPads to be used by Domestics as they don't currently have access to BCUHB computers.

Donning and doffing training was only launched in Q3 of last year, therefore so we hope to see compliance improve in 2022.

Flu Jabs Administered

As of March 2022, 59.9% of all BC HB staff and 59.8% of all priority staff had received the influenza flu jab.



Covid-19 Vaccinations Administered

As of 21st March 2022, 91.5% of BCUHB staff had received at least 1 dose of a Covid-19 vaccination, 89.9% had received at least 2 doses and 77.8% had received their booster dose.

Managers are having conversations with staff who choose not to have the Covid-19 and/or influenza vaccines to discuss any concerns and to gain an understanding of why they feel the way they do. Managers have reported that often, staff who choose not to have the vaccine have experienced an adverse reaction to the vaccine(s) previously, are scared of needles, are pregnant, or are concerned that the vaccination will affect their fertility. There is currently no evidence to suggest that either of these vaccines are harmful to pregnant women or that they affect fertility or reduce the chances of becoming pregnant. The Joint Committee on Vaccination and Immunisation (JCVI) has now advised that pregnant women are more at risk of severe Covid-19 disease and are encouraging them to have their Covid-19 vaccines as soon as possible (UK Health Security Agency, 2022).

The following table shows the percentage of Covid-19 vaccines administered broken, down by Health Community, Managed Service or Service Support Function.

*** Primary Assignments Only**

Health Economy/Pan North Wales Service	% At least 1 dose	% At least 2 Doses	% Booster Dose
Area Teams Central	94.4%	93.6%	83.6%
Area Teams East	93.5%	92.1%	81.3%
Area Teams Other North Wales	96.5%	95.3%	79.1%
Area Teams West	95.0%	94.1%	86.6%
C-19 TTP, Vaccinations and Field Hospitals	92.6%	90.7%	83.4%
Corporate Services	84.9%	82.6%	66.2%
Estates and Facilities	94.9%	94.1%	83.0%
Mental Health & LDS	93.3%	92.0%	80.8%
NW Managed Clinical Services	93.8%	92.8%	82.9%
Womens	94.4%	92.5%	78.7%
Ysbyty Glan Clwyd	91.1%	89.0%	76.0%
Ysbyty Gwynedd	94.1%	92.2%	81.7%
Ysbyty Maelor Wrexham	89.4%	87.2%	74.2%
Grand Total	**91.5%**	**89.9%**	**77.8%**

Lateral Flow Testing for Staff

Guidance on Covid-19 testing and isolation was updated by Welsh Government on 28th March 2022 but still states that all health care staff working in a public / patient facing area, should undertake twice weekly LFD testing.

There is no official way of checking that this is done, but at Ysbyty Alltwen, staff are asked to take a mobile photo of each test that they complete so that they can produce evidence upon request.

Staff Safety

The National Covid-19 Infection Prevention Control guidance continues to be conveyed to staff. One example of this are the below posters which are currently being displayed bilingually in offices in Area West.

In addition, signs like the ones below are displayed throughout BCUHB to help staff and patients to adhere to Covid-19 guidelines.

Safe Bed / Patient Spacing (3.6m)

The scope of the project was not to enforce change but to map the baseline declared bed stock for each area and map the theoretical reduction in beds should all areas convert to 3.6m bed spacing across inpatient care.

3.6m bed spacing on Ward 3, YGC

A baseline review of current bed configurations has been completed for all community and acute sites. The review has been mapped against funded bed base for each site and current configuration changes due to previous Covid-19 management.

In 2022/23, the evaluation of 3.6m bed spacing will be included within all future estates development plans and capital bids.

Safe Entry

One way systems were introduced at all hospitals at the start of the Covid-19 pandemic. Reduced numbers of entrances to sites and compliance with Infection Prevention Control (IPC) guidance upon entry to hospital was introduced across BCUHB.

Entrance at North Wales Cancer Centre

Entrance at Ysbyty Alltwen

Safe Break

The aim of this workstream was to ensure that by December 2021, all staff were able to have a safe break (Lunch & Drink Break) to support their physical and emotional wellbeing with increased staff awareness of benefits and requirements of taking allocated breaks.

Whilst more work needs to be done, there have been some improvements with regards to Safe Break:

- Additional benches and outside areas have been installed on a number of sites
- In staff dining and rest areas, tables and chairs were arranged to allow social distancing
- Clear signage was displayed to ensure staff know how many people were permitted to sit at each table and floor stickers were used to help staff follow the 2m rule
- Some departments/areas have introduced staggered lunch breaks to reduce the number of people in a break area at one time

Twenty-one additional benches and outside areas were installed on the YGC site

Staff dining area in Ysbyty Alltwen

Safe Change

The aim of the workstream was to ensure that:

- accessible changing facilities are available for all staff members interacting with clinical environments
- there is an agreed set of Health Board principles for what constitutes a changing facility
- awareness of and adherence to the uniform policy is increased

Staff representatives from different staff groups across the heath board have taken part in a series of consultation events. A wide range of views and perspectives were collected

about the availability of suitable changing and showering facilities, time to change, consistent implementation of standards of dress and clarity over environments in which these standards apply. Other matters listed as barriers for health board staff included the provision of uniforms and clear pathways to escalate concerns and challenge non-compliance. A summary of the themes identified is now under consideration and will inform the 2022/23 Safe Change plan.

New changing facilities have been provided in some areas of the Health Board and some practical changes have also been introduced:

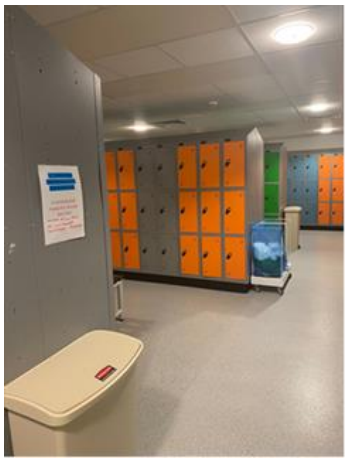
New shoe storage

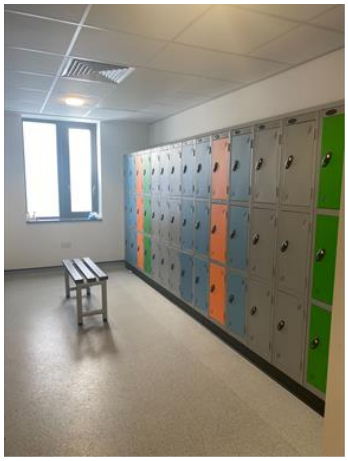
- Shoe storage is now provided in some changing areas so that shoes do not contaminate lockers or other surfaces
- Some departments/areas have introduced staggered start and finish times to reduce the number of people in the changing area at any one time
- In some departments/areas, staff are no longer allocated a permanent locker to store their belongings. This prevents staff from leaving things in the changing rooms after their shift which creates a cluttered environment which is difficult to clean
- Cleaning wipes are provided to clean the lockers after each use

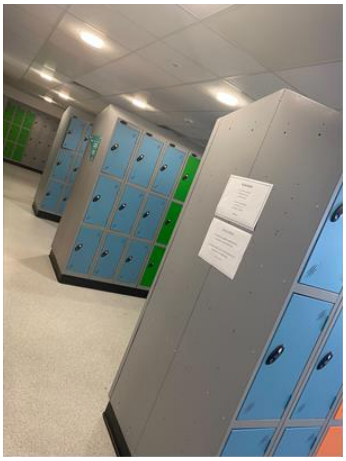
Previous changing facilities at YGC

8

New changing facilities at YGC







Previous changing facilities at Ysbyty Alltwen

New changing facilities at Ysbyty Alltwen.

Other project tasks for 22/23 are as follows:

- Develop a set of principles for Safe Change within the Health Board
- Raise awareness of the changing facilities & expectations to all staff
- Identify required changing facilities
- Ensure there is adequate changing facilities across the Health Board sites to bring about the behavioural change
- In conjunction with Workforce & OD, develop a booklet (escalation of concern regarding uniform)
- Review all uniforms (practicality of, for different areas including Community)

Safe Space

The Workstream encountered a significant number of staff changes including a change of Senior Responsible Officer during the first 90 days of the programme. Therefore, a whole new team was established at the start of the second 90 days of the programme and substantial progress was made, however additional volunteers did not step forward to undertake clinical leadership roles and chair the task and finish groups.

The Workstream was able to secure the support of a deputy SRO, however that was 5 months after the start of the programme.

Safer Front Door

Unscheduled Care Segregation/Isolation/Safe Transfer to Inpatient Ward

The aim of the workstream was to ensure that no patient was transferred to an admission ward from the Emergency Department (ED) without an available Covid-19/respiratory result and that all high risk patients requiring admission onto a base ward from ED were appropriately isolated/segregated within the department until a result was known.

An Infection Prevention Exceptions DATIX report was developed to assist staff in the exception reporting of failure to isolate newly suspected infection risk inpatients within 2 hours and any patient moved to a base ward without an available Covid-19 result.

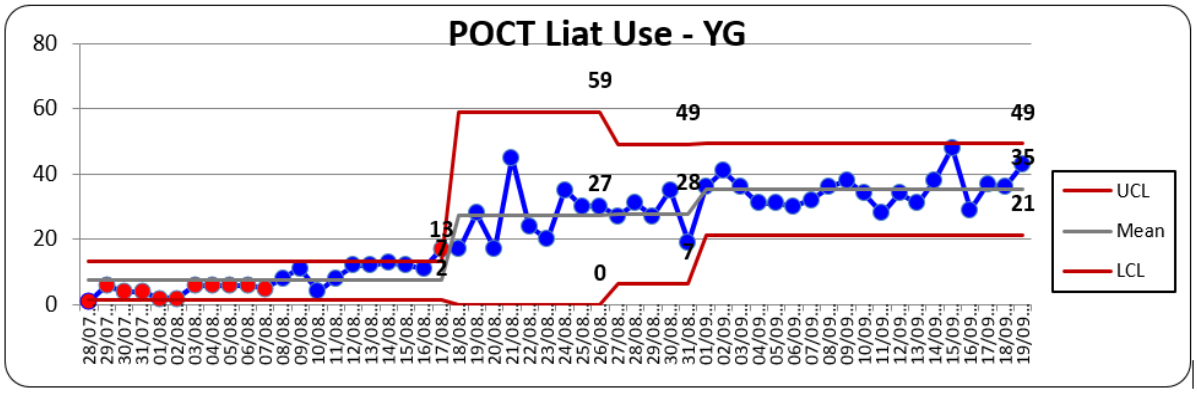
Prisoners at HMP Berwyn were required to take a Lateral Flow Test and a Polymerase Chain Reaction (PCR) test on their first day of arrival and another PCR test on Day 6. If the results were negative they were released into the wider population of prisoners on Day 10.

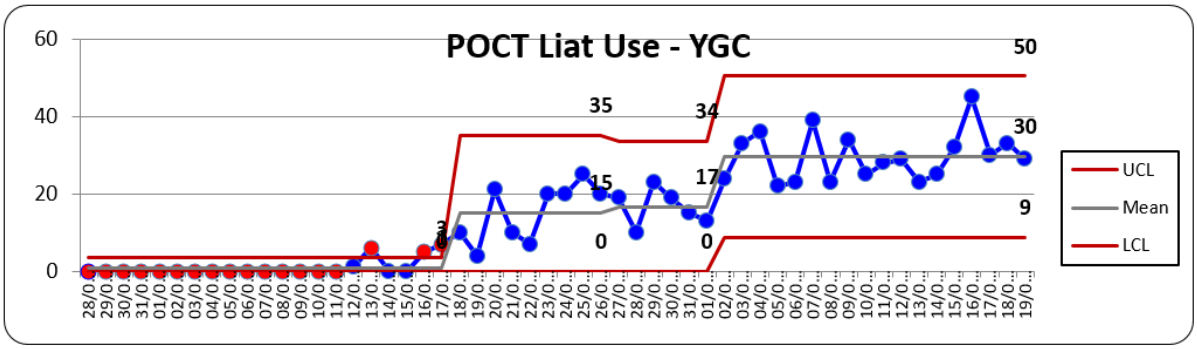
Results Management

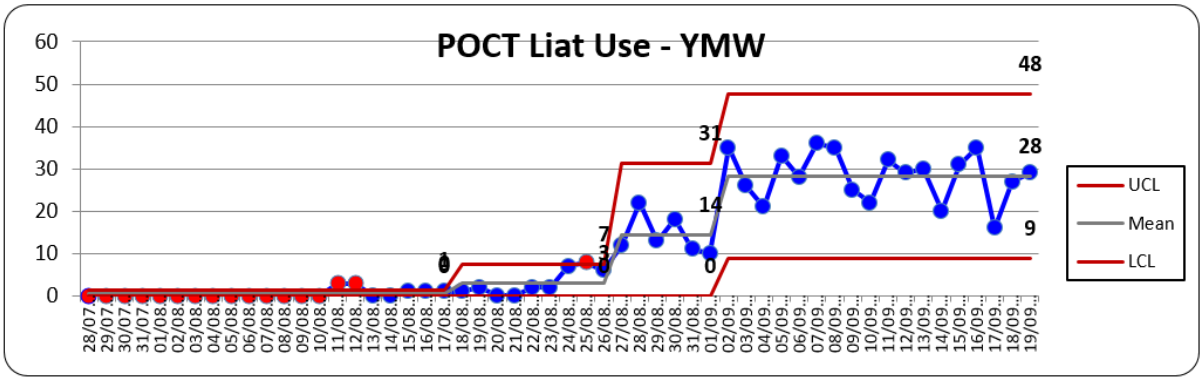
Following the Toyota commissioned rapid improvement diagnostic activities, subsequent work with the operational teams and Test, Trace, Protect (TTP) resulted in the LIAT Point of Care Testing kits, which provide Covid-19 test results within 20 minutes, being rolled out in all three Emergency Departments. Staff training on how to use the new Point of Care Testing (POCT) machines commenced in July 21. These POCT machines are now being used for all adult patients who may be admitted, however there is a need to ensure that the changes are being sustained and the turnaround times don’t increase.

The Statistics Process Control (SPC) Data charts below highlight step change in numbers point of care testing (POCT) carried out for emergency admissions once the SOP had been introduced in August 21.

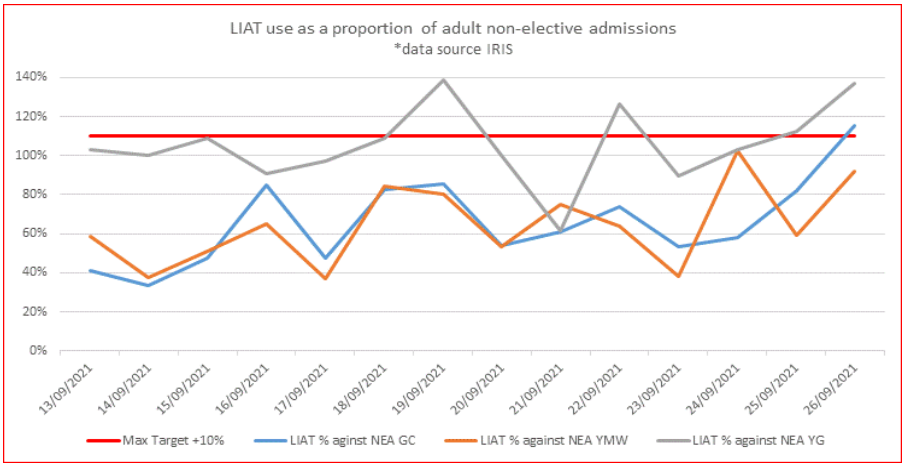
Chart 1 LIAT use as a proportion of adult non-elective admissions 13/9 - 26/9/21







A Roche LIAT machine in use - Emergency Department



Safe Access

Safer Access to Clinical Areas

The aim of the project was to ensure that all clinical areas remain at maximum or below occupancy rate, to reduce footfall of roaming staff. The project did not progress due to insufficient staff resource required to support the delivery, however the majority of Health Communities and Pan North Wales Services report compliance with the undertaking of risk assessments in clinical and non-clinical areas. In addition, signage is being used to show the maximum number of people allowed in each area at one time and hand sanitiser and hand washing facilities are provided.

Safe Ward

Routine Inpatient Covid-19 Testing

It was agreed that all inpatients should have a PCR test on admission, after 48hrs and then twice weekly until their date of discharge. The Standard Operating Procedure was signed off and moved from implementation phase to Business as Usual.

In February 2022, a weekly report was developed by Informatics to enable Heads of Nursing to access compliance rates of Covid-19 testing for all inpatients and to provide assurance through LIPG meetings. Following a successful pilot, the report was handed over to operational teams and Heads of Nursing for implementation in their inpatient areas.

Due to a change in guidance relating to Covid-19, routine inpatient testing is not currently taking place, however patients are still tested on admission and if they display any Covid-19 symptoms.

Virtual Working

Some teams and departments have implemented virtual working where possible. Examples include:

- Virtual group clinics
- Virtual outpatient appointments
- Telephone triage
- Agile working

Virtual working reduces the number of people visiting our sites and decreases the number of admin and non-essential staff at acute sites, thus reducing the risk of transmission of Health Care Acquired Infections. It also has the potential for delivering out of hours, supporting work life balance and supporting retention. It also allowed shielding staff to work from home,

Virtual Ward Rounds

The aim of the project was to introduce virtual ward rounds to reduce footfall on the wards, however it was stood down as there was no clinical appetite for it.

Virtual Board Rounds

The aim of the project was to introduce virtual board rounds to reduce footfall on the wards. This project is now being led by the Unscheduled Care programme.

Safe Transfer

Rapid Isolation of Patients newly suspected of being an Infection Prevention risk

The project's aim was to ensure that any patients newly suspected of being an Infection Prevention risk, anywhere in the hospital was isolated within 2 hours.

An Isolation risk matrix has been developed to be used as a decision making tool. It allows ward staff to understand if it is safe to move patients and enables Clinical Site Managers (CSMs) to make decisions about the appropriateness of moving patients to a side room, therefore improving the effectiveness of their use.

An e-form is in the process of being developed to complement the isolation risk matrix. The paper format has already been piloted in Wrexham Maelor and whilst the e-form will follow the same process, it will enable data to be stored on SharePoint and accessed by CSMs when reviewing the infection status of patients in side rooms and reviewing occupancy rates. The aim is for the e-form to eventually feed into the STREAM bed management system, however resource issues within Informatics are currently causing delays.

Safe Action

The main aim of the Safe Action workstream was to bring about behavioural change of our Staff, our patients and visitors to our organisation. Through a review of the learning from the BCUHB Health Care Associated Infection (HCAI) panels and outbreak meetings, key areas required for focused interventions and application of quality improvement methodology were identified.

Visibility of Leadership

The aim of the project was to increase the visibility and accessibility of our Leaders (clinical and non-clinical).

COM B events were held for Nursing & Midwifery staff and was a useful vehicle to access a large number of staff to gain their insights, experiences and opinions on the importance of Visible Leadership to aide a feeling of value. This in turn positively affects culture and behaviours in the workplace. The outcomes of the COM B events have informed the BCUHB Nursing System Framework with a core aim being releasing leader's time to be with their teams. This will also lead to the development of a suite of tools, from suggested interventions.

There has also been development and acknowledgement of close links between the Visibility of Leadership Task & Finish Groups and the Stronger Together programme.

The next phase of Immersion Events with Medical and Non Clinical Staff are going to be arranged via the Stronger Together programme and will apply the same approach / methodology to ensure we are listening to the workforce.

The option of implementing "back to the floor" methodology is going to be explored in 2022/23. The proposed aim is for our Leaders (8a and above) to spend (in the first instance) 10% of their time per month "back to the floor" with the goal of increasing to 10% per week.

The project will also explore the possibility of utilising e-roster to record time spent on the wards (Quality Assurance) on time sheets to provide data set of 10% of Band 8a or above.

Due to Covid-19 social distancing restrictions, the majority of Visibility of Leadership events (and indeed other Safe Action events) had to be held over Microsoft Teams, which can often hinder staff engagement.

Patients Walking with Purpose

The aim was to launch the co-produced clinical guidance for the safe infection prevention and control environment of care for the patient who walks with purpose.

The guidance was developed following completion of the following:

- A literature review was undertaken regarding the Impact of Covid-19 on the Patient Walking with Purpose

- Four COM B Immersion events held (supported by Public Health Wales) – multi disciplinary approach (including representatives from the Patient Users Experience Group)
- A Big Conversation held to share Patients Walking with Purpose deliverables and outcomes / findings of COM B events.
- Engagement with Allied Health Professionals, Public Health Wales (PHW) and Dementia Consultants which has provided expert knowledge when / where required.

This 'Patient Walking with Purpose' project has been accepted as a 2021 Bevan Exemplar for the cohort 7 programme (Doing things differently for a Prudent, Sustainable Recovery). The Programme will be supported by the Bevan Commission to develop and test innovative ideas over a 12 month period. BCUHB will collaborate with PHW with the ambition for a joint publication.

Phase 2 of project will also include the following:

- Collaborating with PALS and Dementia Consultant Nurse(s) to develop a co-produced piece of work looking at the standards expected between public and staff in the care of patients who walk with purpose.
- Reinstating our Patient activity rooms and group activities (supported by a Standard Operating Procedure to ensure safety of our patients and staff).
- Launch the guidance document across North Wales (previously shared with Health Boards across Wales during April 2022 Dementia Friendly Hospital Charter for Wales Launch Event).

The greatest risk to the project is that the guidance will not be utilised by staff, however this is mitigated with the launch and communication for Health Board wide use.

Infection Prevention Policies & Procedures

Review of Infection Prevention Policies & Procedures

All updated Infection Prevention policies & procedures are now live on the BCUHB intranet page; although some of these are yet to be approved by the Health Board, alongside the updated Covid-19 Toolkit providing easy access to information required by clinical areas / staff as required. In addition:

- a recording of the Big Conversation held 29th September 2021 is available via SCC-HF Betsi Net page and Ward Accreditation Intranet page for staff to watch / access when required
- the quarantining of patient belongings and definition of sessional use of masks has been approved and included within the Covid-19 Toolkit
- a new Hand Hygiene e-form and electronic report has been developed by the Informatics Development Team
- an Acuity Matrix has been developed to support staff during an outbreak

It is hoped that in phase 2 of the SCC-HF programme, the frequency / mode of collection for Infection Prevention audits (e.g. Commode audit, Isolation audit etc) will be agreed, a handbook will be developed for wards to refer to (detailing escalation, frequency, lead and access for audits) and a protocol will be developed to support the Acuity Matrix.

Infection Prevention Champions

The aim is for every ward and/or team to have or be able to contact a trained Infection Prevention Control (IPC) champion to support BCUHB Staff, Patients & Visitors to safely use PPE and other IPC practices aimed at minimising the risks of all HCAIs by at least 25%.

There are currently 157 IPC champions across BCUHB and to date over 400 nominations have been received for Champions in clinical areas.

Infection Prevention Champions training has commenced for Non Clinical Staff and a heat map (accessed via the SCC-HF dashboard) has been developed to record where our Infection Prevention Champions are located. This heat map will help our Local Infection Prevention Groups identify gaps / training needs in the future.

Due to site pressures, attendance at our training programme has been lower than anticipated however we are now reviewing and updating our training programme / schedule with the aim of more staff being able to attend.

The recruitment and training programme for Non-Clinical Champions will continue in phase 2. A MDT Task & Finish group will also be set up to identify Champions and support the implementation of the programme within Primary Care and a training programme approach / plan will be developed.

The SCC-HF programme will work in collaboration with the Continuous Improvement, Staff Engagement and IPC teams to motivate staff to become Infection Prevention Champions, attend training and thereafter maintaining momentum and motivation. They will also aim to provide Infection Prevention Champions with the confidence and ability to challenge peers when guidance or best practice is not adhered to.

Donning & Doffing

The aim of the project is to ensure staff compliance with Donning & Doffing techniques and the clear messaging / understanding for our patients and visitors.

Donning and Doffing Mandatory Training (level 1 and 2) is now live on ESR and is included as mandatory for all BCUHB employees. In addition, information has been circulated pan

BCUHB with instructions for staff on where to access training and e-learning guides. Training is also live via @NHSWales to enable students and agency workers to access and complete.

An assessment of current guidance is on display for patients, staff and visitors to ensure the version approved at the PPE steering group is the only version in use, so that the message is consistent across the organisation. Staff information has been developed to provide the reader with infection prevention guidance regarding PPE (including Donning & Doffing). This leaflet will provide key messages for staff about expected best practice
The Donning and Doffing mandatory training data has been added to the ESR compliance dashboard and will be monitored accordingly.

Patient Discharge & Transfer

The projects aim was to ensure that patients discharged from, or transferred between or within hospitals have information about any infections and associated treatments shared with health and social care staff to inform their care.

Patient Screening information (including contact identification) is now automatically shared with our Test, Trace and Protect (TTP) colleagues and a patient Covid-19 discharge passport has been developed which will provide patients, their relatives and / or care givers information re Infection status.

In collaboration with the Safe Acute / Community Hospital Transfer Programme, the Task & Finish Group have approved the following documents from an Infection Prevention perspective:

- Acute Nurse to Nurse Safe Ward Handover document;
- Safer Transfer (Community to Acute / Acute to Community) document;
- Community Hospital Safety Huddle document;
- Pilot West Discharge Training programme (for roll out pan BCUHB).

Safe Visitor

Inpatient Visitor Guidance

Covid-19 Inpatient Visitor Guidance has been launched and embedded BCUHB wide. Phase 2 will look at ways of displaying and monitoring adherence with the guidance.

All Visitors to BCUHB Inpatient Areas are now required to complete / evidence a negative Lateral Flow Test before entering the Ward / Area(s) to reduce HCAIs /Zero avoidable Nosocomial.

Inpatient Visitor LFT kits initially had to be ordered via the Welsh Government, which at times has caused a delay in tests being delivered and was outside of our usual Oracle /order system. In October 2021, The Lead Manager of Operational Delivery for Antigen (Public Health) worked with North Wales Shared Services colleagues to arrange for these tests to be ordered via Oracle (the usual BCUHB stock ordering system). Ordering Inpatient Visitors LFT kits via Oracle has resulted in an easier ordering process for staff and faster delivery.

The protocol for Inpatient Lateral Flow testing has now been approved and shared (via the Covid-19 Toolkit) for implementation in all Inpatient areas pan BCUHB.

The rolling out of the project / protocol via vulnerability group allowed a programme of Plan, Do, Study, Act improvement cycles (PDSAs) to develop a standard template of documentation / risk assessment for all services across BCUHB to implement (to ensure a consistent approach embedded).

A Celebration event was held to mark the completion of the Inpatient Visitor Lateral Flow Testing Task & Finish Group (attended by the Deputy CEO / Executive Director of Nursing & Midwifery).

Catheter Acquired Urinary Tract Infections (CAUTI)

The aim of the project is to ensure that all Registered Nursing staff are 100% aware of and compliant with completion of the Urinary Catheter documentation with the aim to reduce Catheter Acquired Urinary Tract Infections.

My Urinary Catheter Passport (for all patients across North Wales living with a catheter) has now been launched and will be provided for all patients /or anyone else involved in the care of patients with a catheter. The information enclosed in the passport will help patients care for their catheter at home and ensure their carer / healthcare professional has the correct information.

As part of the project, the following documentation has been reviewed, updated and tested:

- Intentional rounding (to include the HOUDINI method)
- Catheter pathway (Insertion bundle)
- Blocked catheter flowchart
- TWOC flowchart

The point prevalence survey to provide baseline data and improve current care and the safety of patients with urinary catheters is now complete and informatics are currently working towards providing an electronic solution for collection of Catheter numbers and associated infections. This data will be analysed to develop further Quality Improvement work to reduce infections.

Staff Engagement

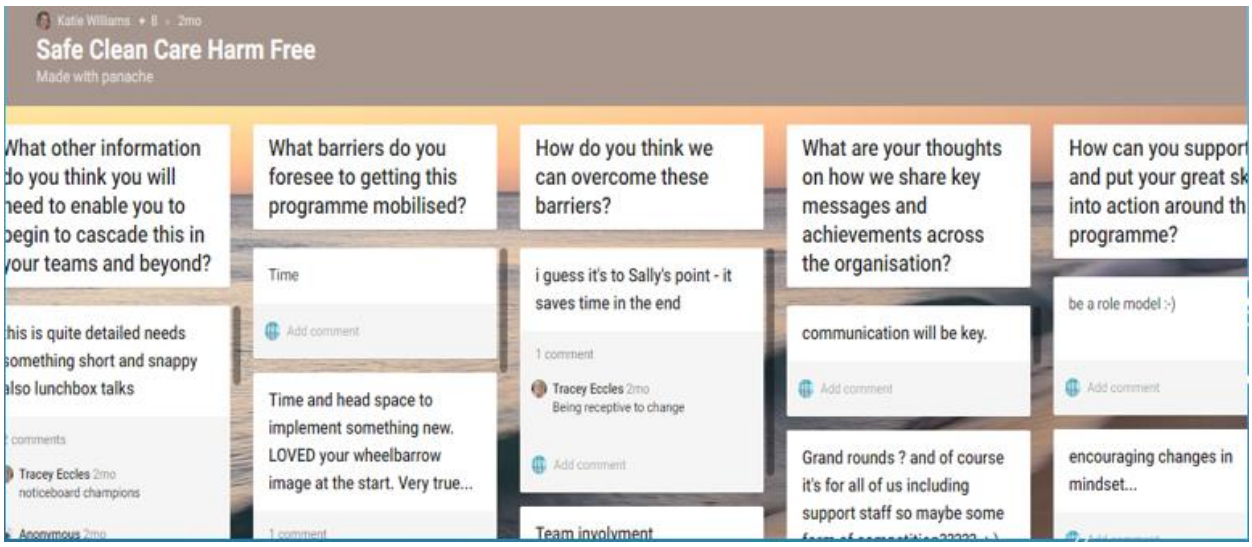
As members of the SCC-HF Steering Group, the Organisational Development team (OD) have enabled key linkages to be made between SCC-HF and Mewn Undod Mae Nerth/Stronger Together. They have also provided guidance, support and advice on innovative virtual engagement methods to enhance staff engagement and involvement in SCC-HF in a Covid-19 secure manner. Training has been provided for members of the Steering Group and their teams to enable them to use virtual engagement tools, such as Padlet and Mentimeter, when engaging with staff, with the training session recorded and a written guide produced to promote the use of these virtual engagement tools more widely.

The OD Team have actively promoted SCC-HF through a number of staff networks including the staff engagement ambassadors, the Be Proud Pioneers, coaches with a workshop held for Matrons on the Matrons development programme. The virtual engagement resources have also been shared with the new Infection Prevention champions.

A 'You Said/We Did' virtual board has also been created to further support engagement with staff around the key messages and actions of SCC-HF.

The key themes to emerge from the immersion Visibility in Leadership events have also been shared with and included as part of the Discovery phase of Mewn Undod Mae Nerth/Stronger Together. In addition the staff engagement team have provided support to the Workstreams including;

- Training session around methods of engaging virtually with staff
- Guide and recording of training session created on methods of engaging virtually with staff
- Promotion of SCC-HF with various network including SEA, Pioneers, Coaches, Matrons on development programme
- Session on SCC-HF with matrons on development programme
- Tour of new SP site with Be Proud Pioneer teams – take through video clips and encourage sharing of case studies – e.g. Ruthin community hospital
- Links with IPC Champions Group – resources and toolkit examples shared



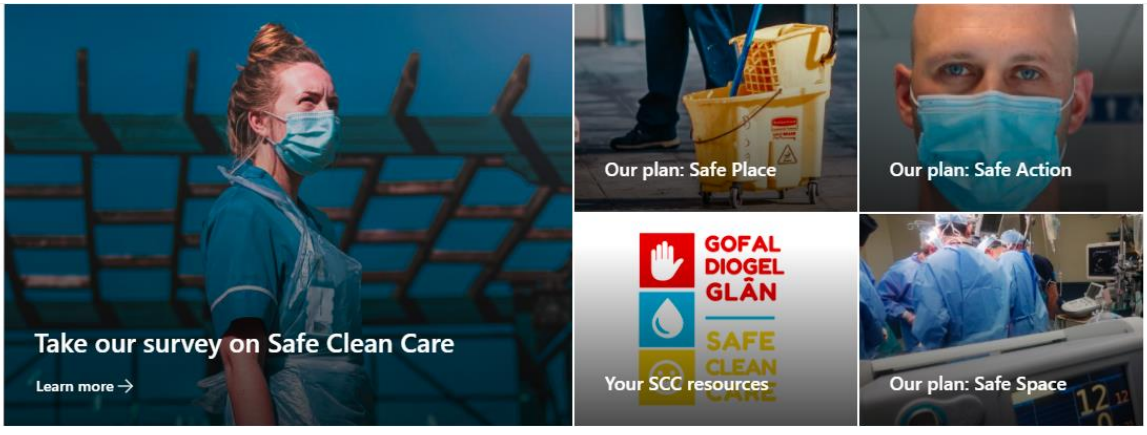
The OD team will continue to support SCC-HF in an advisory role.

Communications Team

To support the delivery of the SCC–HF programme, the Health Board's communications team created a Communications Plan (approved by the board in March 2021).

Actions delivered as part of this communications plan include:

- **Creation and circulation of a comprehensive staff survey, supported by IPC Champions and staff ambassadors** Around 300 people from all staff groups have responded to our initial survey, with a thematic analysis of responses presented to the wider programme steering group
- **Creation of a new SCC–HF hub / resource on the staff intranet**, bringing together information, news and resources from the campaign and all materials relevant to IPC in our hospitals and other settings
- **A suite of programme videos** have been filmed including the project lead and leaders of all three Workstreams to be shared by staff, staff ambassadors and IPC Champions
- **Creation of a library of SCC–HF branded documents, posters and pledge cards** to be shared with staff to showcase support across the health board's estate



In addition:

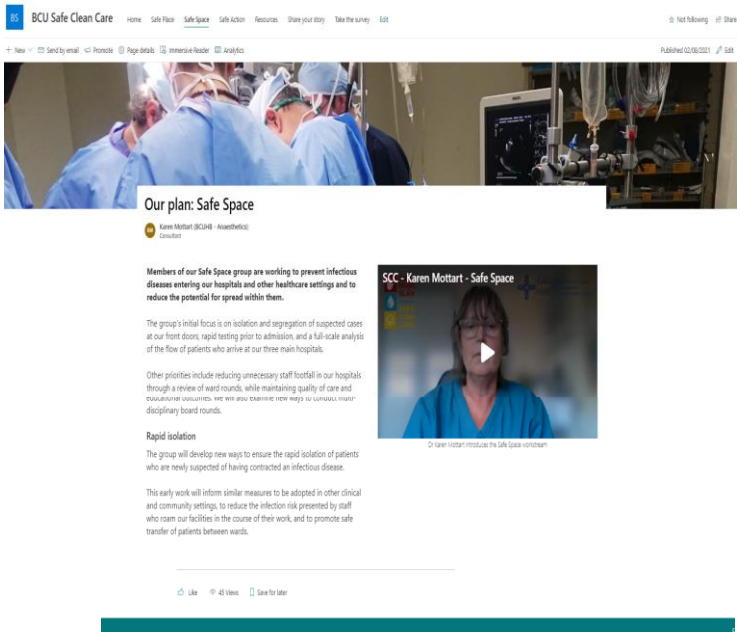
- Updates have continued through established internal communication channels, including the Health Board Bulletin and staff app
- Updates relating to patients and visitors have continued through established external communications channels, including social media and the Health Board's website
- A wide range of staff have taken part in a number of immersion events held by colleagues as part of the work of programme task and finish groups
- The communications team continues to support training sessions currently being delivered to IPC Champions, helping them to navigate resources and supporting the dissemination of positive programme messages

New monthly SSC–HF briefing

The SCC–HF Communications Plan identified front-line leaders and managers, nurses and temporary staff as the priority audience.

Insight gathered from front-line staff as part of our SCC–HF survey confirms many prefer or require direct and face-to-face information cascade rather than communication via digital channels.

A new dedicated SCC–HF briefing is being shared with all matrons, ward managers, clinical leads and community nurse managers each month. This briefing is designed to be shared with all staff on the ward or clinical area face-to-face during shift handover and/or at team meetings, to ensure effective personal cascade throughout the organisation.



The briefing is also circulated to Hospital Management Teams for inclusion in safety huddles and is shared with IPC Champions and Staff Ambassadors for onward dissemination to teams.

It focuses on action taken by the SCC – HF programme and what this means for front-line staff, with clarity about the steps they need to take and is supported by other communications channels where appropriate.

Informatics

The Business Intelligence Unit (BIU), sitting within the BCUHB Information Department, aims to deliver the right information to the right people at the right time. The key objective of the BIU within SCC-HF is to develop a suite of key performance indicators to support the overarching programme, individual work streams and wider Infection Prevention team. Underpinning this objective is the need to improve both the availability and accessibility of information. In addition, many areas require standardisation and streamlining of recording processes to prevent duplication of data entry and improve data quality.

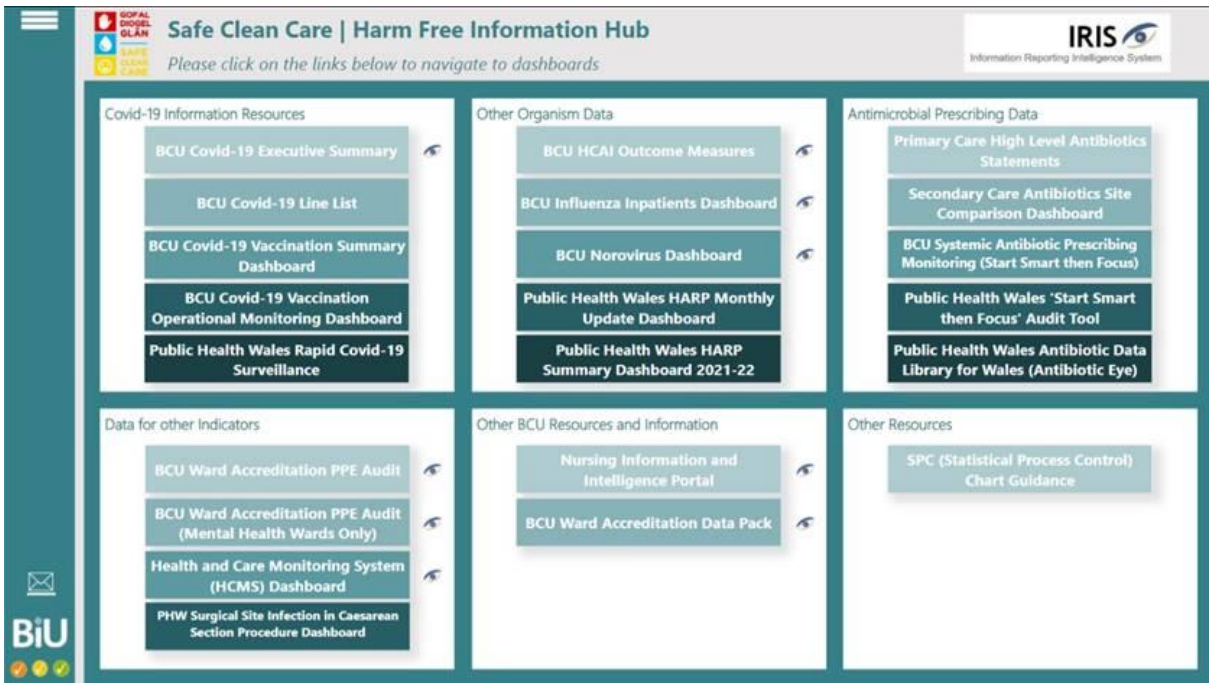
Approximately 48 key performance indicators were initially identified to support SCC-HF and further measures of success requested by the Safe Space, Safe Place and Safe Action work streams. Within each domain, the datasets and measures required for reporting have been defined and form the basis of the BIU work plan under SCC-HF. Making this information available to the programme varies in complexity for each of the different measures – ranging from expanding existing reporting to establishing new data sources and developing reporting methodologies.

There are two key strands under the umbrella of making data more accessible – first, the development of a single point of access for SCC-HF reports and second, to develop reports that can be seamlessly disaggregated from the overarching programme level to operational service delivery. The tools to support our accessibility aim would be the existing Information Department reporting tool, IRIS and chosen business intelligence software, Power BI. The team are also working closely with the wider Information Department to ensure linkage between new and existing reports such as the Nursing Information Intelligence Portal.

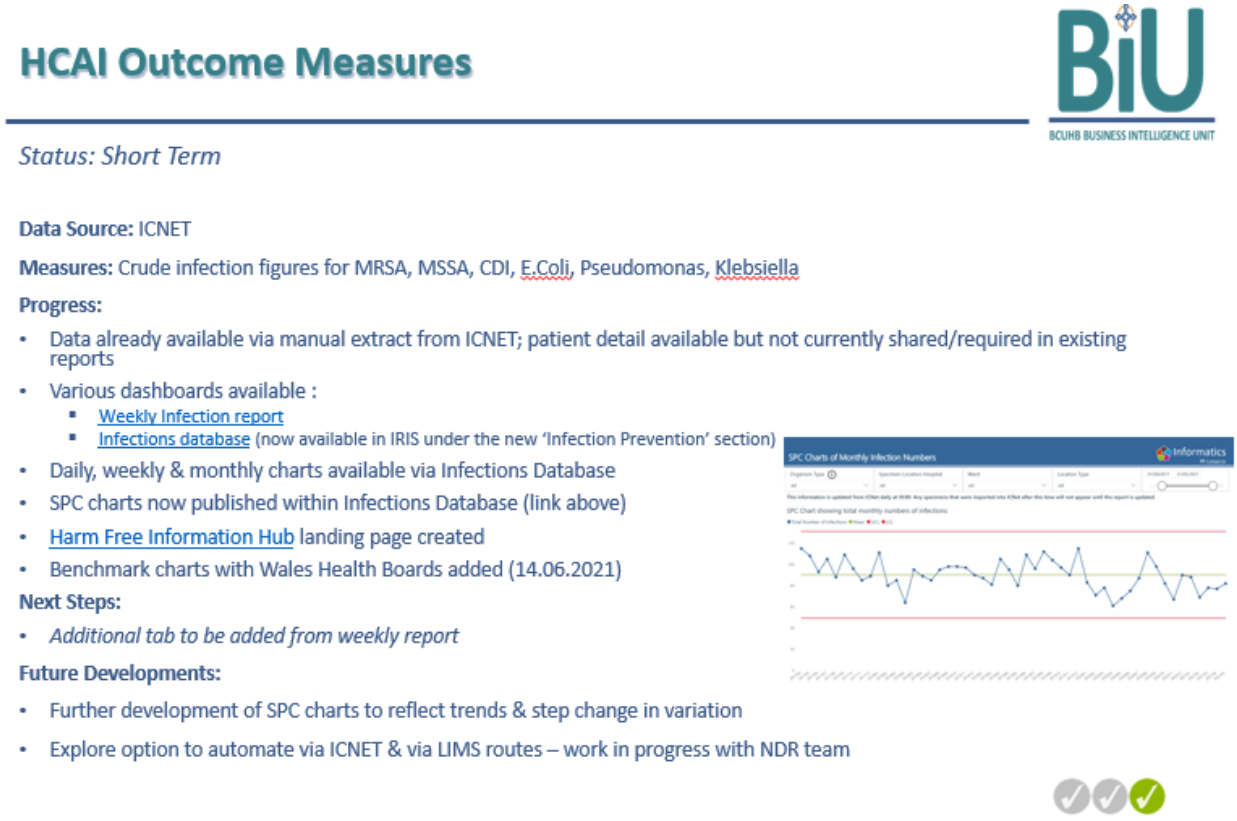
Our achievements to date include establishing a home for SCC-HF via the new Infection Prevention folder on IRIS and the creation of the Harm Free Information Hub. The hub is a means of supporting users to navigate between the many and growing number of SCC-HF reports available including signposting to external sites, such as Public Health Wales dashboards and guidance for interpretation data. Reporting has also been published on the following topics with Statistical Process Control charts available in several reports to support the understanding of variation and monitoring of improvements.

- Welsh Government Reportable Infections
- Flu
- Norovirus
- Covid-19
- Hand Hygiene and Commode Audits
- Exploratory work is underway on Respiratory Syncytial Virus and Antibiotic Resistance.

This is the opening page on IRIS for the SCC-HF dashboard



An example of a report that can be accessed on the dashboard is shown in the screen shot below;



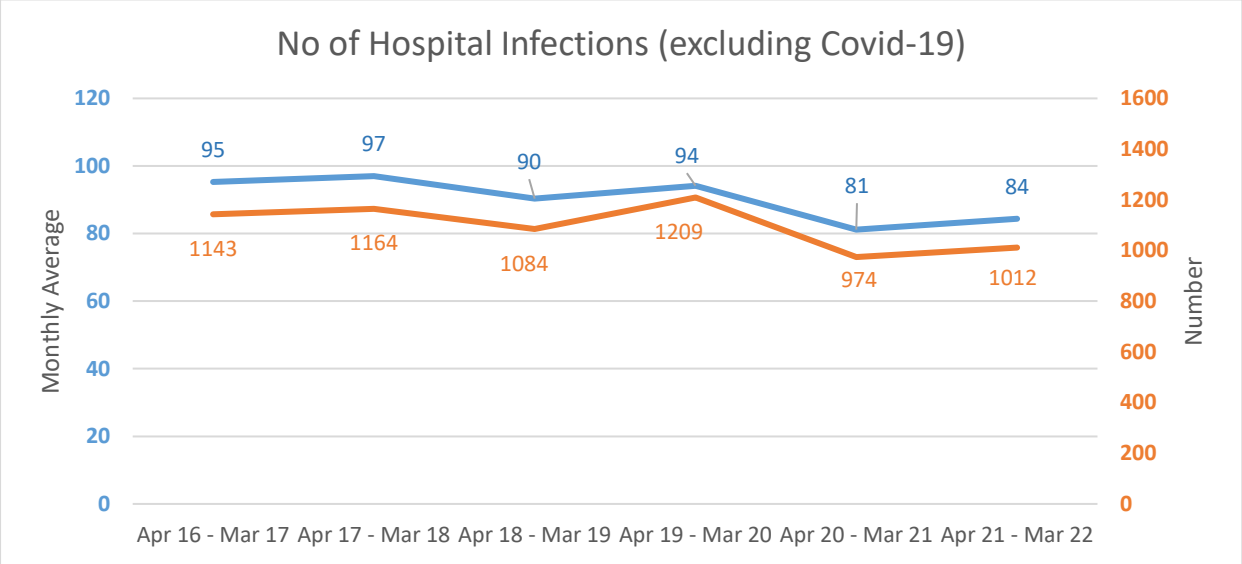
The following measures have been prioritised as the next key developments for SCC-HF. In addition, a user guide will be developed to support the use of the Harm Free Information Hub.

- Credits for Cleaning
- Red Cleans

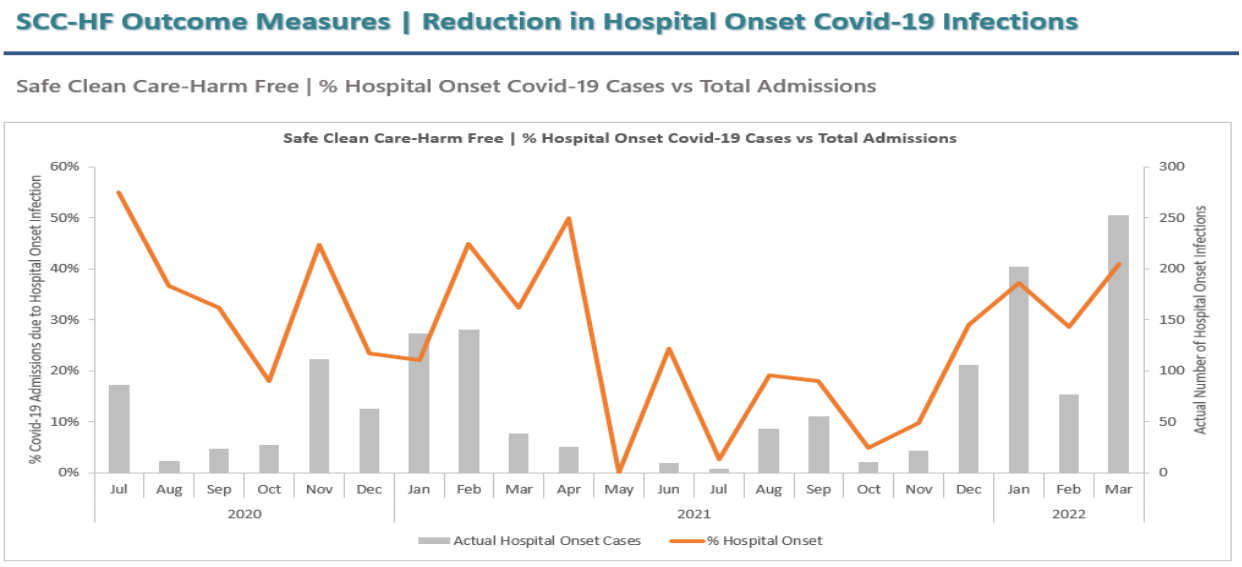
- Mandatory Training Compliance including Infection Prevention Levels 1 & 2 and Aseptic Non Touch Technique modules
- Inpatient tracking for Covid-19
- KPIs for Safer Front Door including Point of Care Testing compliance

HCAI Performance Data

Whilst the number of reported hospital infections in BCUHB was higher in the last 12 months compared to last year, the numbers in 20/21 and 21/22 were both lower than in the previous four years.



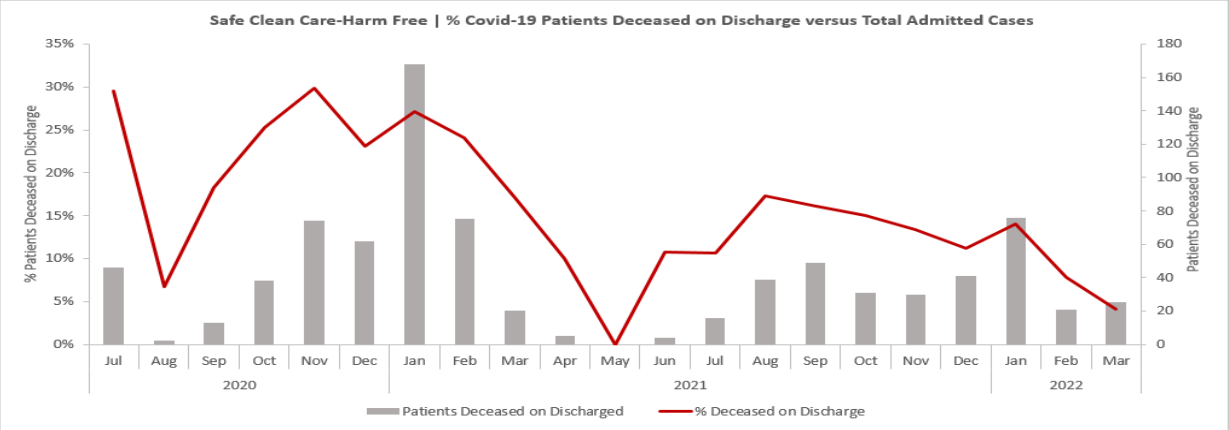
As of March 2022 month end, the % of admitted Covid-19 cases due to hospital onset infection was 27**%** for 2021-22 to date. This position has improved compared to the 2020-21 rate of **32%** (July to March inclusive).



As of March 2022 month end, the % of admitted Covid-19 cases where patients were deceased on discharge was **11%** for 2021-22 to date. This position is improved compared to the 2020-21 rate of **25%** (July to March inclusive).

SCC-HF Outcome Measures | Reduction in Deaths for Admitted Covid-19 Cases

Safe Clean Care-Harm Free | % Covid-19 Patients Deceased on Discharge versus Total Admitted Cases



Interpretation note | The change in hospital onset cases is measured in the above graphs as a percentage to account for fluctuations in community transmission, which in turn impacts the number of admissions.

Challenges

Despite the significant progress that has been made, there are certain elements that are yet to be achieved and embed as Business as Usual (BAU) activities.

There were significant resource challenges in all of the workstreams, mainly due to dedicated staff resource not being allocated to the programme and instead staff doing it as an ‘extra add-on’ activity, staff leaving the organisation or moving into new roles and difficulties attracting and recruiting staff to secondments and fixed term posts.

Informatics were involved in the programme but unfortunately, they were unable to provide sufficient resource to the level of expertise that was required to enable some of the projects to progress. Many of the projects required measures and measurement systems that do not currently exist as well as a dashboard that evidences adherence to new SCC-HF Standard Operating Procedure and changes to processes. However, great progress has been made in recent months and an overarching launch page has been developed so that staff only need to access one site to view all the SCC-HF data.

Covid-19 restrictions have meant that many members of the programme team have been working remotely, therefore they have been unable to provide any onsite facilitation and have been unable to work with ward-based staff on testing changes and implementing and

embedding improvements. There is a real risk that this could have a detrimental effect on staff engagement and the delivery of the programme.

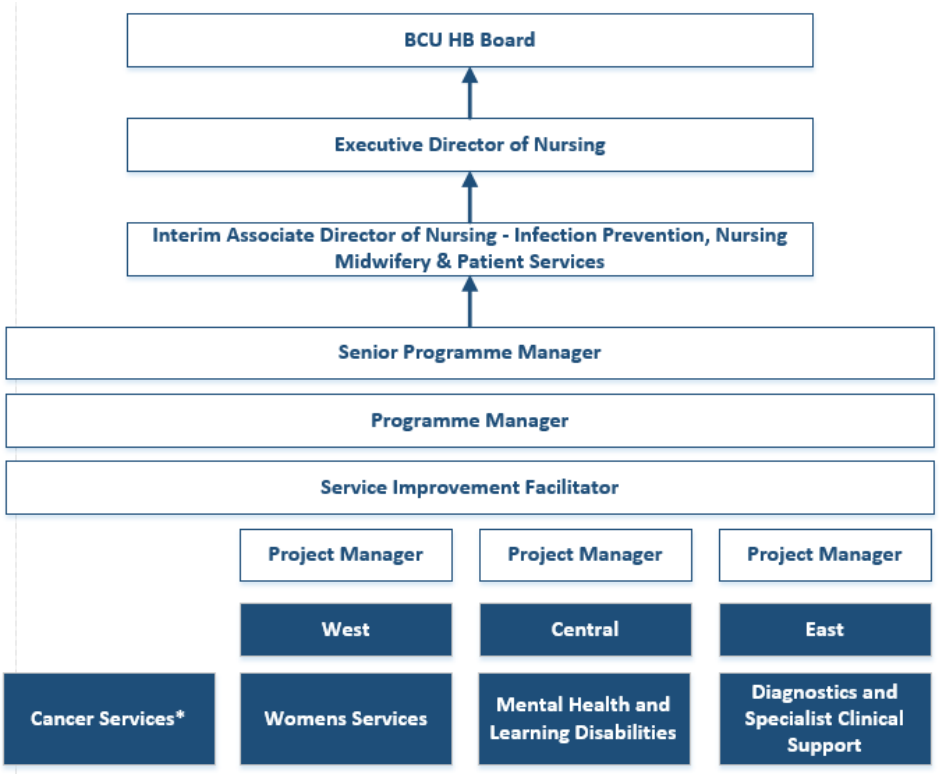
As a result of the Covid-19 surge in December 2021, as well as BCUHB's focus on the Booster vaccination programme, the SCC-HF steering group was paused from December 2021 until February 2022, which contributed to the programme being unable to achieve its aim. The unpredictability of Covid-19 and the requirement for BCUHB's surge response continues to be a risk to the delivery of phase 2.

A variation in attendance at Task & Finish groups and the Steering group and a lack of medical engagement has also restricted progress and meant that some projects were unable to start.

Phase 2

It is proposed that Phase 2 of the programme would make a number of modifications to align to BCUHB's new operating model, moving away from the requirements of a Senior Lead / SRO (Senior Responsible Officer) for each of the workstreams Safe Place, Safe Space and Safe Action workstreams and will instead focus on embedding SCC-HF throughout BCUHB so that it becomes Business as Usual. The new model would move towards an integrated professional approach to support the programme, remove barriers, using champions and link into other transformation and change pieces of work.

Phase 2 of the SCC-HF programme will align to BCUHB's new operating model.



*** Project managed by Programme Manager**

Health Care Acquired Infection Themes

Phase 2 will see the SCC-HF programme focus on 14 Health Care Acquired Infection (HCAI) themes that have been identified and prioritised by and other staff across BCUHB.

In phase 2 the SCC-HF programme will run a quarterly campaign to promote and encourage compliance with IPC guidance. Each of the 14 themes will be addressed in the following four campaigns:

- Proud of our place
- Making space safe
- Rapid learning
- Safe action saves lives

The first campaign 'Proud of our Place' is scheduled to launch in June 22 and is designed to support our wards and departments to take pride in their environment. It will involve:

- **The launch of a 5S poster:** An A2 poster will be provided to enable teams to record their progress using images. The poster uses the 5S methodology: Sort, Set in order, Shine, Standardise and Sustain.

- **Promoting opportunities to Clear the Clutter:**

  SCC-HF will work with colleagues in Estates and Facilities / Portering to provide extra opportunities to ‘dump the junk’.

  This poster will be used to provide details of local collection dates and be displayed throughout BCUHB.

- **Introducing the 15 Step Challenge:**

  The 15-step challenge will be introduced to all wards and departments across the health board. Postcard-sized cards can be completed by (or handed to) anyone attending the ward, to obtain instant, qualitative feedback on first impressions

The future quarterly campaigns will include;

Making Space Safe

- **Promoting Standard IP Precautions** for Standard Operating Procedures, focusing on appropriate use of PPE, cleaning bed spaces (particularly around who cleans what), what type of clean is needed, and the deep clean programmes
- **Social distancing for all** to reinforce the need to limit footfall on wards and to minimise the number of physical staff at handovers, supporting the reduction of staff movement, and reinforcing safe bed space layout for patients to eliminate overcrowding
- **Empowering patients** by revamping patient information on how to prevent HCAIs. This will include the use of posters, leaflets, stickers, and social media

Rapid Learning

- **Outbreak management** will include the launch of the new policy and clear outbreak summaries with improved processes for rapid shared learning
- **Post Infection Reviews** will simplify the process, supported with clear PDSA cycles and videos, to facilitate rapid shared learning, embed the learning into practice and to improve medical engagement
- **Bi-monthly Infection Prevention Newsletter** to further share findings and learnings so the whole health board can learn, and so that the same mistakes are avoided in other areas

Safe Action Saves Lives

- **Screening and testing**. Promoting the importance of prompt action reviewing (isolation and sampling), and improving how long it takes to get results for all potential HCAIs. This will include implementing a new testing SOP for COVID-19 (including more LFT and POCT), and to reiterate the critical importance of checking results and acting on them promptly
- **Management of invasive devices** including vascular devices, urinary catheters, and blood culture taking. This supportive work will take the form of reviewing associated paperwork alongside education and training incl. ANTT, 'Skills for safety' prompt cards for staff and 'Preventing HCAIs' handbook for staff, with clear criteria to refer for second opinions and further support

The campaigns will be developed through a task and finish group approach with leads from each of the accountable areas. Material will be developed, and utilising spread methodology through our collaborative approach, will support mobilisation and implementation over the next 12 months. It is hoped that these campaigns will support the accountable areas approach around delivery of their zero tolerance to HCAIs culture.

-END-

Appendices

APPENDIX A: Project Status as at January 2022

	Project Status	Definition	No of projects at that stage	% of projects at that stage
	Project Near Completion	Task & Finish Group closed down, evidence of embedding and sustainability required	9	36%
	Project Live	Task & Finish Group still running, more work needed to be done	8	32%
	On Hold	Project has not progressed and is currently on hold	7	28%
	Hybrid Project	Another programme or team is responsible for its delivery	1	4%

	Task and Finish Group	Project Status
1.	**Safe Place**	
1.1	Clean ward/hospital	
	Covid-19 cleaning addendum/decant of areas	
	Ventilation	
1.2	Review bed spacing across BCUHB	
1.3	Safe entry	
	One way system and signage	
	Reduced number of entrances to sites and compliance with Infection Prevention Control (IPC) guidance upon entry to hospital	
	Lateral flow testing for patients coming in for face to face appointments	
	Reduced number of admin staff on site	
1.4	Safe break	
1.5	Safe change	
2.	**Safe Space**	
2.1	Safe front door	
	Unscheduled care segregation/isolation/safe transfer to inpatient ward	
	Results management	
2.2	Safe access	
	Safe access to clinical areas	
2.3	Safe wards	
	Routine inpatient Covid-19 testing	

	Virtual ward rounds	
	Board rounds	
2.4	Safe transfer	
	Rapid Isolation of Patients newly suspected of being an Infection Prevention risk	
3.	**Safe Action**	
3.1	Visibility of leadership	
3.2	Patient walking with purpose	
3.3	Infection prevention policies and procedures	
	Review of infection prevention policies and procedures	
	Infection prevention champions	
3.4	PPE: Donning & doffing	
3.5	Patient discharge & transfer	
3.6	Safe visitor	
	Inpatient visitor guidance	
	Inpatient visiting lateral flow testing	
3.7	Catheter acquired urinary tract infections (CAUTI)	

APPENDIX B: Plans on a Page

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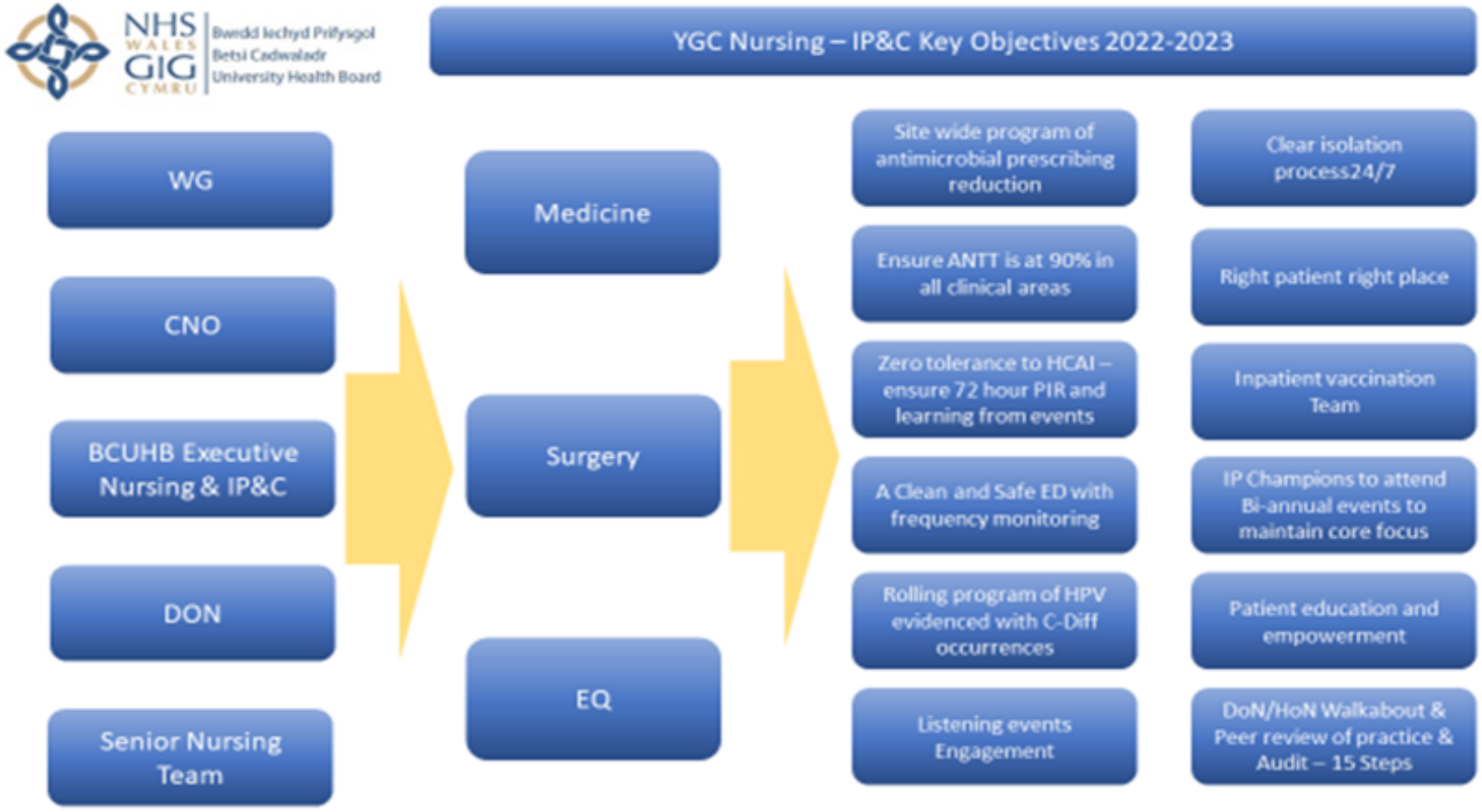
Central – Ysbyty Glan Clwyd & Abergele Hospital

Slide 1/2



Central – Ysbyty Glan Clwyd & Abergele Hospital

Slide 2/2

Medicine, EQ and SACC & Theatres
YGC and Abergele

- Ensure ANTT is at 90% in all clinical areas
- Patient education and empowerment
- Zero tolerance to HCAI-ensure 72 hour PIR and learning from events
- Challenge Poor IPC Practice

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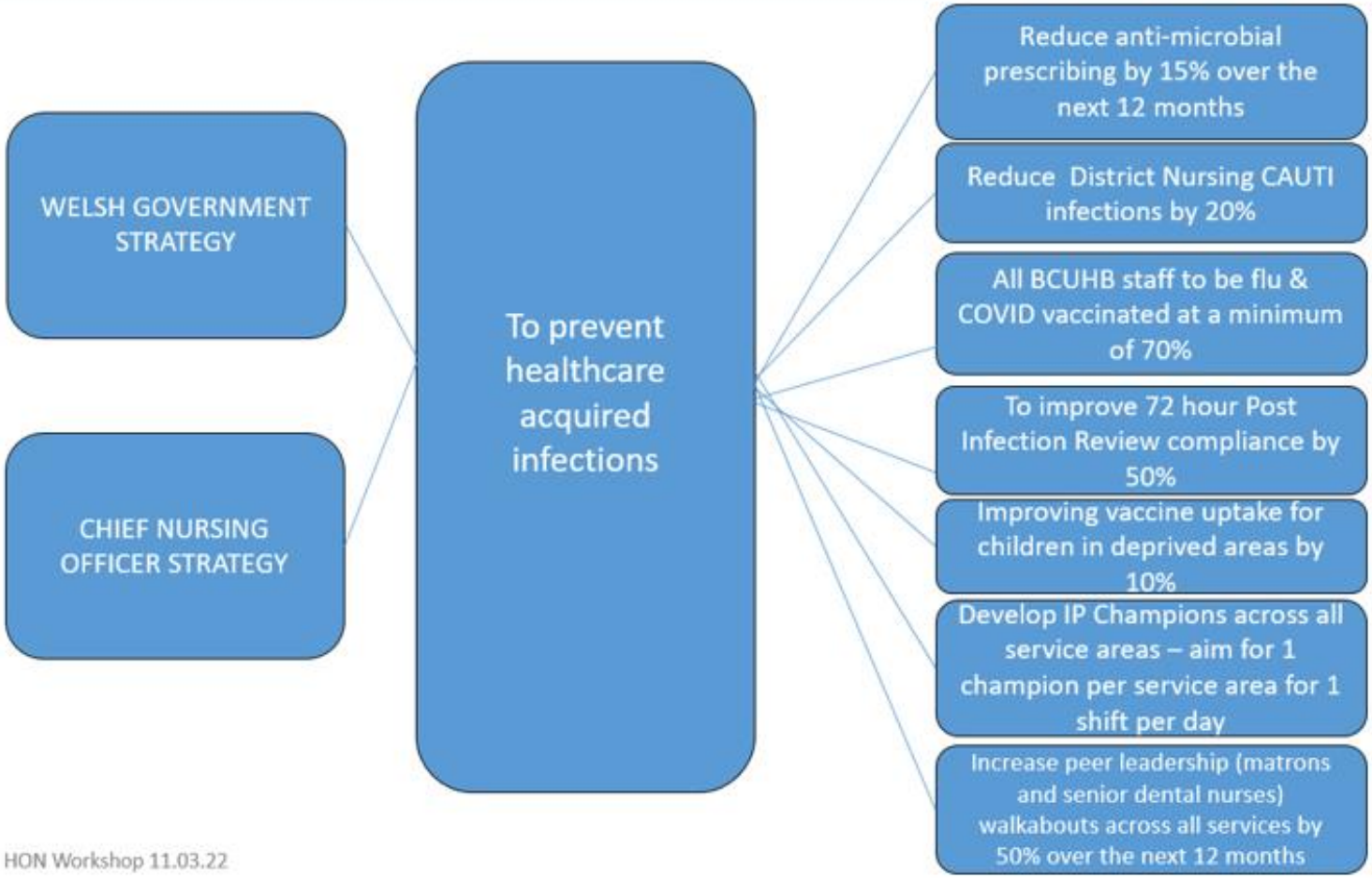
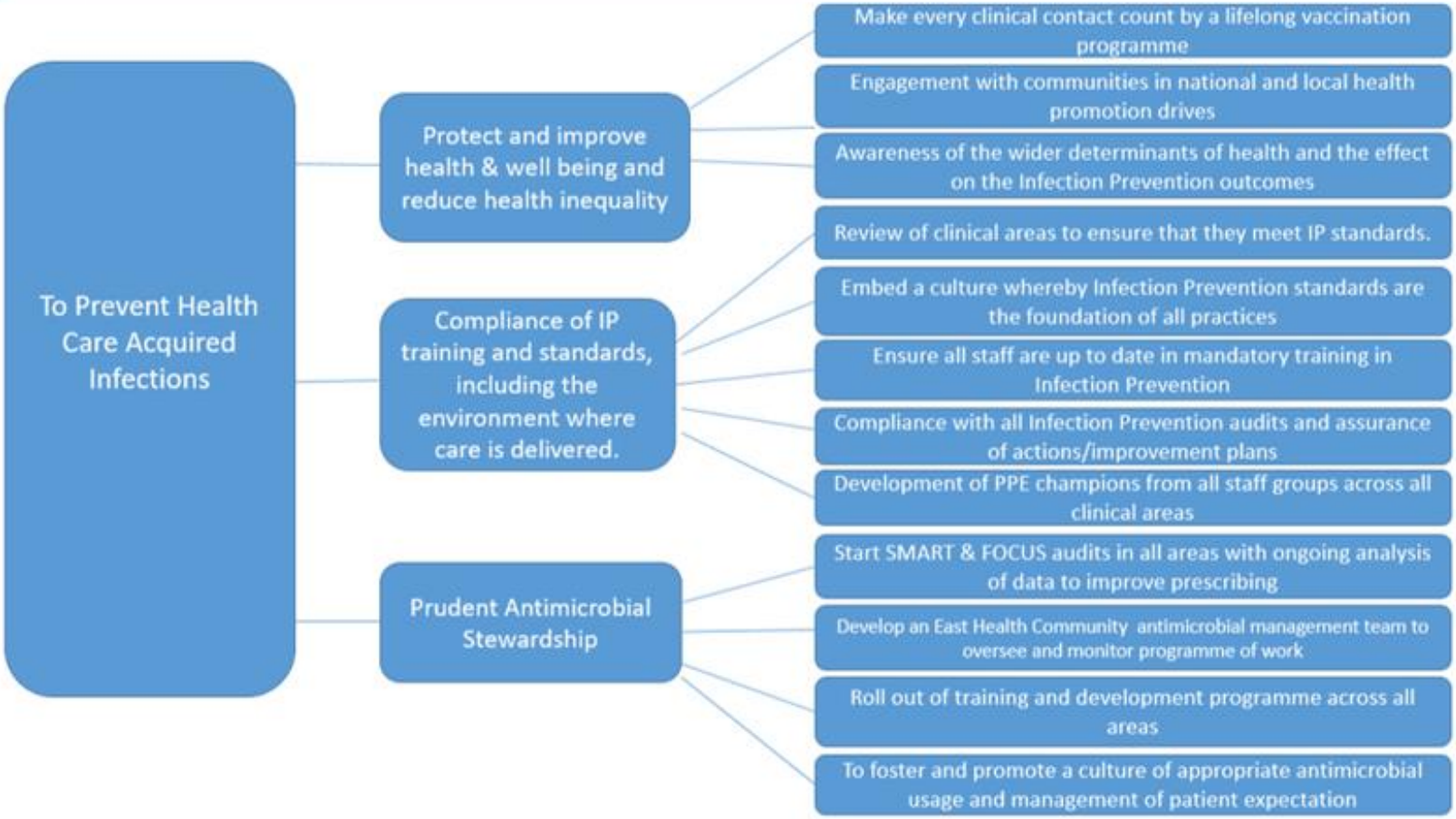
Betsi Cadwaladr
University Health Board

Central Area Team



HON Workshop 11.03.22

East Health Community – Area & Acute



Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

West – Ysbyty Gwynedd
Slide 1/2

VISION: Zero tolerance approach to HCAI by March 2023

FOUR KEY AREAS: Our Patients | Our Staff | Our Environment | Good Governance

OUR ACTIONS

Aim/Objectives

- To ensure that effective and meaningful IPC practice, knowledge and skills are embedded into the everyday practice of all staff, within the West health economy. The aim is to ensure that effective measures for the prevention and control of infection are integrated into core business, planning and delivery.
- YG aims to prevent the risk of HCAI throughout the diversity of settings within the West footprint to promote the key message that IPC is everybody's responsibility.
- Patients and the public who receive care are confident that they are cared for in estate and environments where IPC measures are always achieved.
- Responsive vaccination programme for patients and staff.
- To reduce the number of nosocomial infections year on year
- To have a robust governance framework that provides assurance to the Health Board.

Measures

- Agenda Item on all area YG team/HMT/Q&S agendas
- Escalation to IPSG
- PADR objective for all staff
- Monthly SCC meetings, LIPG
- Monitoring of compliance with IP staff training- 85% and above
- HCAI data – Reduce C-diff incident by 30%
- 72 hour PIR completion
- HCAI scrutiny meetings
- IPC audits as per BCUHB policy
- Senior leaders /staff walk about in all services
- SCC monthly plans
- Vaccination uptake data
- Risk assessments – environmental and clinical delivery
- C4C oversight and delivery of actions
- Compliance with clinical bundle compliance

Drivers/Controls

- Infection outbreak- local and national- response plans
- National guidance
- Welsh Government Reporting
- Local policy and guidance
- Public Health determinants
- Welsh Government vaccination targets
- BCUHB values
- Consistent, robust leadership
- Feedback and lessons learnt
- Patient, staff and carer experience
- Risk assessments with agreed mitigation
- Risk register reviews

Improvement Actions

- Senior leaders /Staff walk about
- SCC plans to be agreed and signed off by senior nurses – April 2022
- 72 hour PIR completion and dissemination of learning
  - Support teams to meet vaccination targets – ongoing
  - 100% completion of clinical bundles
  - Fit testing programme oversight
  - AAA oversight at bi-monthly HMT performance reviews

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University Health Board

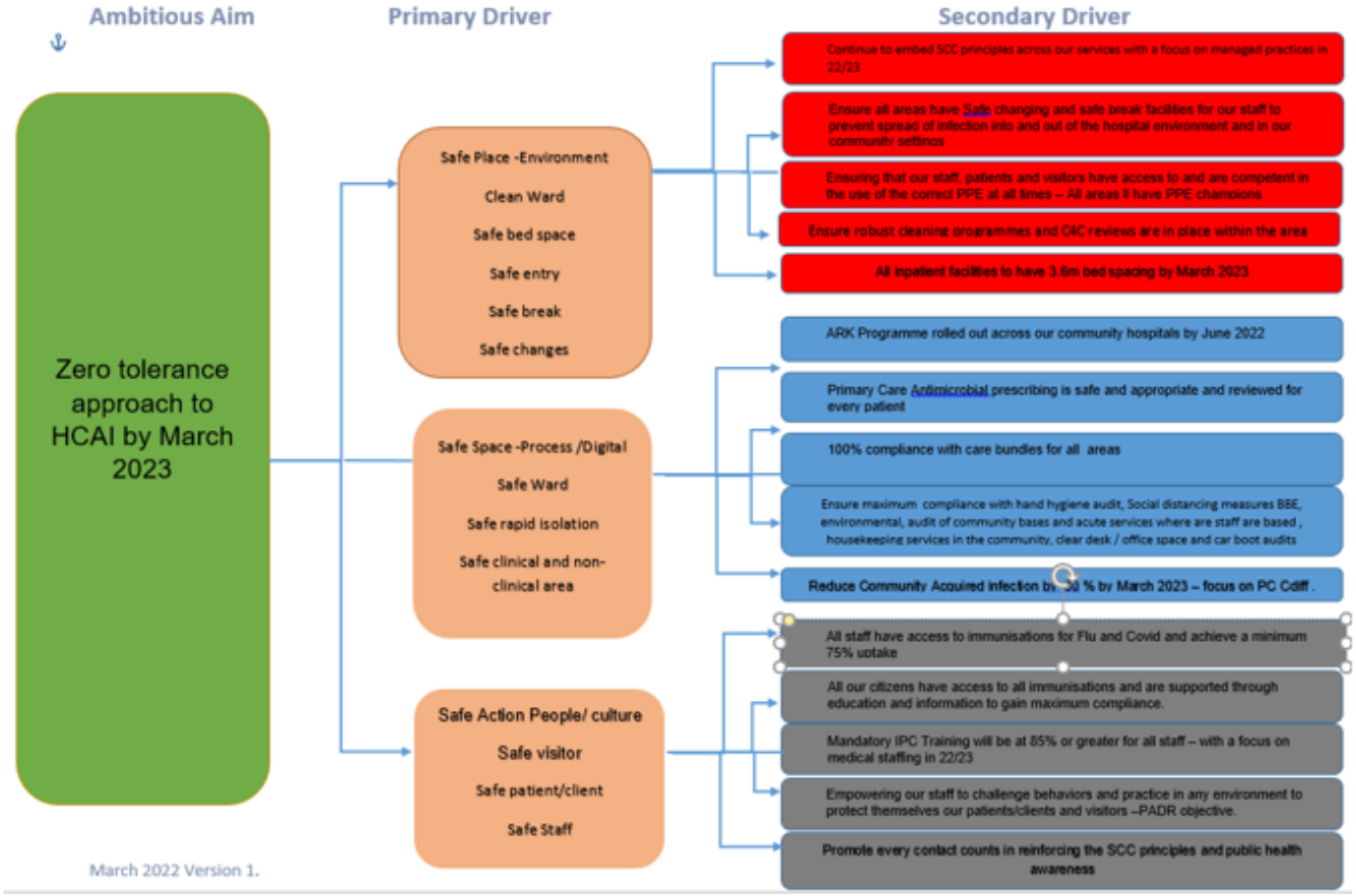
West – Ysbyty Gwynedd
Slide 2/2

AIM	HOW?	MEASURES
Infection Prevention Agenda is everybody's business	• Re-launch of Safe Clean Care with named lead and multidisciplinary forum • Each ward/department to have own improvement plan • Engagement from all staff – all grades and departments – ownership and pride in their areas/departments. • All wards / departments to have named safety and IP reps. • Regular positive publicity and feedback to all staff. • Reward for wards and departments that consistently achieve sustained improvement • Raise public awareness of infection spread / outbreaks and their role in prevention. • Raise patient awareness, encouraging regular hand hygiene after toilet and before meals • Accountability reviews/meetings – all wards/clinical areas • IP themes awareness to be raised through safety huddle/exhibitions/agenda item in all meeting	• RAG status improvement plans with clear dates and evidence based completion. • Sustained consistency within: Mandatory training records - ESR. Ten key standards 100% compliance • Reduction in all HCAI - Infection rates remaining below trajectory
Environment meets the required Infection Prevention Standards.	• Risk assessment of building for the key risks – programme of works to be in place with an identified lead. . • Hand washing facilities in every bay and every entrance to all clinical areas. • Replacement flooring and white rock cladding • Increased frequency of cleaning - additional staff to ensure sufficient to consistently maintain high standard frequency cleaning schedule. • Isolation facilities and bed spacing • Rota of HPV cleaning for all clinical and facility areas in all wards • Business cases for funding of staff and structural improvements • Regular de-cluttering of all areas	• Site environmental improvement plan – RAG status – with clear achievable target dates. • Monitoring all cleaning to achieve High scoring C4C audits consistently • Senior walkabouts/matrons audits • Reduction in HCAI - Infection rates remaining below trajectory
Consistent and sustained staff compliance with all aspects of Infection Prevention	• Development of leadership supervision programme for Infection Prevention • Leadership – challenging poor compliance • Accountability reviews ward manager, matron, HoN, DGM, CL • Compliance with uniform policy - All staff to be in uniform including medical • Screening and isolation of patients admitted with diarrhoea • Adherence to PPE – regular updating with donning and doffing • Regular education updates, on ward training • Winter vaccination programme	• 100% compliance with mandatory IP and ANTT training • 100% compliance with PIR completion within 72hours. • Audit of uniform policy/ Matron audit • 100% admission screening for Covid-19 and MRSA • 100% completion of all PVD and catheter insertion and maintenance bundles • 95% compliance with eligible staff vaccination • Reduction in HCAI - Infection rates remaining below trajectory
Timely and appropriate interventions and treatment	• All Patient receive timely reviews and implementation of care and treatment – sepsis screening and sepsis 6, C diff pathway and review on confirmation • Robust antimicrobial stewardship rounds for all clinical areas with consultants in attendance • Targeted education for GPs and Junior Doctors on antibiotic prescribing • Prescribers to review all antibiotics (PPIs and laxatives) already given and to discuss with microbiology before prescribing off guidance. • Focused intervention on bundle compliance for catheter insertion, venflon and cultures.	• Compliance Measured and Monitored via IRIS • Sustained 100% compliance with SEPSIS 6 • Improvement in compliance with antibiotic audits. • Audit cdiff pathway • Ward audits, matrons audits and walkabouts to include compliance with PPE
Governance Framework for monitoring and assurance	• Overall site harm reduction improvement plan with identified actions, leads and target dates. • Risk assessments and risk register entries where risk identified. • Agreed meetings with set dates, regularly reviewed and updated TOR and mandatory MDT attendance to ensure full engagement • Reporting structure from Ward to Board Ward report to Divisional Q&S meeting/accountability Divisions report to Site IP Group Site IP Group report to the IPSG	• Reports generated. Meeting minutes • Monthly formal review of risk register • Reduction in HCAI - Infection rates remaining below trajectory

West Area – Driver Diagram

Slide 1/2

Primary Care, Children's, Therapies, Community Hospitals, Community Services, Pharmacy



West Area – Plan on a Page

Slide 2/2

Primary Care, Children's, Therapies, Community Hospitals, Community Services, Pharmacy

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VISION: Zero tolerance approach to HCAI by March 2023

FOUR KEY AREAS

- Patient, Service User and Carers
- Staff: permanent, temporary, external contactors and third party
- Environmental: Hospital, Community and Primary Care
- National and local policy guidance and reporting

OUR ACTIONS

Aim/Objectives

- This commitment will help to ensure that effective and meaningful IPC is embedded into the everyday practice of staff, within the West Area. It will also ensure that effective measures for the prevention and control of infection are integrated in the West Area core business, planning and delivery.
- The West Area aims to prevent the risk of HCAI throughout the diversity of settings within the West area to promote the key message that IPC is everybody's responsibility.
- Patients and the public who receive care within our areas of responsibility are confident that they are cared for in estate and environments where IPC measures are always achieved .
- Responsive vaccination programme

Measures

- Agenda Item on all area west team/SMT/Q&S agendas
- Escalation to IPSG
- PADR objective for all staff
- Monthly SCC meetings, LIPG
- Monitoring of compliance with IP staff training- 85% and above
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- Compliance with clinical bundle compliance

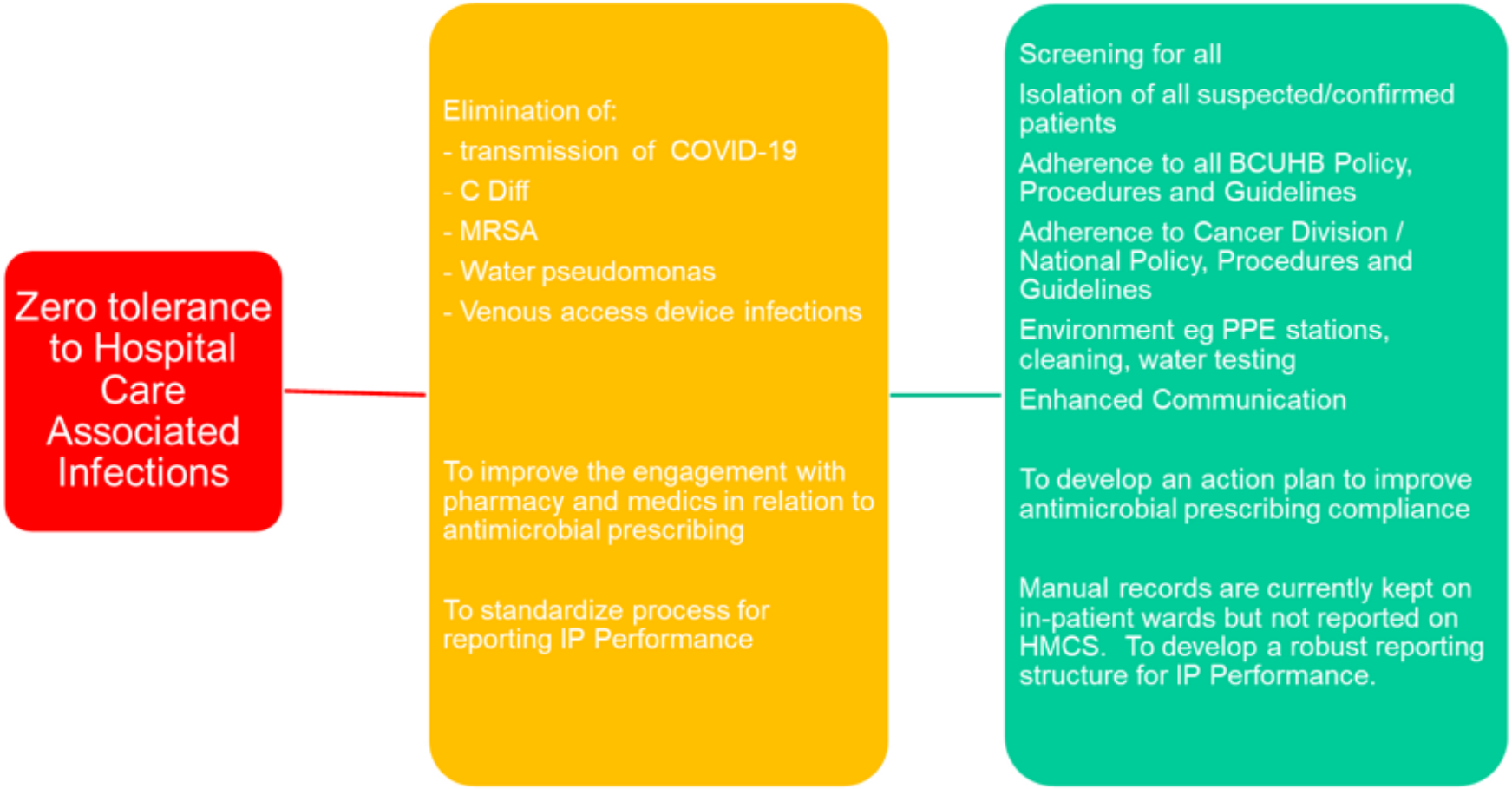
Drivers/Controls

- Infection outbreak- local and national- response plans
- National guidance
- Welsh Government Reporting
- Local policy and guidance
- Public Health determinants
- Welsh Government vaccination targets
- BCUHB values
- Consistent, robust leadership
- Feedback and lessons learnt
- Patient and carer experience
- Risk assessments with agreed mitigation where required

Improvement Actions

- Senior leaders /Staff walk about -
- SCC plans to be agreed and signed off by senior nurses – April 2022
- 72 hour PIR completion – ongoing
- Increase IP team visibility and support in community sites- June 2022
  - Support to services where required to meet vaccination targets – ongoing
  - 100% completion of clinical bundles

Cancer Services



Mental Health & Learning Disabilities

Vision

To ensure MHLD Division follows the latest guidance on IPC to keep our patients and staff safe and protected from nosocomial infections across all inpatient and community settings including the person's home environment

Four Key Areas

- Administration measures for the respiratory care pathways
- Implement Standard Infection Control Precautions
- Compliance in PPE including respiratory protective equipment
- MHLD IPC Governance

Our Actions

All MHLD inpatient settings will be assessed for patient 'cohorting' in light of any updated guidance and hospital SOPs updated

Procedures for patient leave from MHLD settings to be followed

Patient LFT visitor guidance to be followed in all areas of the Division

PIRs completed for all hospital onset cases

Perform Hand hygiene as per World Health Organisation 5 moments

Display information on respiratory and cough hygiene

Ensure clinical environment is well maintained, good state of repair, visibly clean and free from clutter

Responsibility of the person in charge to escalate if environment is not clean

Follow BCUHB decontamination procedures

Responsibility of person in charge to ensure all staff follow dress code / uniform policy

All staff must be compliant in BCUHB expectations for wearing and disposal of PPE (Aim for 85%+ compliance with donning and doffing PPE module)

Staff who undertake physical restraint to follow PHE guidelines on PPE

Division will undertake random audits of PPE compliance

Risk assessment completed for placement and storage of PPE for all inpatient settings

Ensure high levels of Fit Testing compliance

HON exception report and representation at Division IPC

Each SLT to strengthen C19 IPC Champions and have staff complete the IP MOOC

Learning from outbreak control meetings distributed for learning across Division and embedded and presented to the Executive COVID scrutiny panels

IPC training compliance reported through Division IPC meeting

Credits for cleaning & Daily COVID audits reported through Division IPC

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North Wales Community Dental

Aims:

- To provide and support the full range of dental services, safely, with a continuing zero tolerance to healthcare acquired infection
- To support community and hospital oral health improvement initiatives which help prevent sepsis and pneumonias.
- To deliver an evidence-based framework of assurances, underpinned by sound data collection and reporting mechanisms.

Key Objectives / Assurance Framework

Maintaining a Safe Place: Our environment and equipment

Work environments risk assessed, inspected and audited on an annual basis.

Annual update of NWCDS strategic planning document ("Building for Smiles")

Annual review of Ventilation provision in all dental clinics and demonstrable progress to achieving site improvements to WHTM 03-01 (or equivalent) 10 AC/H. minimum.

Inventory of equipment updated annually.

Compliance with required validation, testing, maintenance and servicing processes.

Increase peer site reviews by 50% over the next 12 months

Annual review of Safe changing facilities for clinical staff and demonstrable progress to achieving improvements.

Annual review of facilities for staff safe breaks and demonstrable progress to achieving improvements.

Ensure that our staff, patients and visitors have access to and are competent in the right protective equipment at all times

All areas are clutter free to reduce the risk of environmental infection burden

Patients are triaged to prevent cross contamination and to assign to appropriate care pathway.

Compliance with rules about room capacity and usage by staff, patients, accompanying persons, to maintain safe working environments.

Providing a Safe Space: Our people, policies and procedures

All staff will be receive training to raise awareness of their roles in SCC, the updated Plan on a Page objectives.

Compliance with WHTM 01-05 and all relevant emerging national guidance, including decontamination of PPE.

Compliance with environmental and enhanced cleaning standards.

Compliance Policies, procedures, SOPs; for Universal and Respiratory disease transmission status.

Compliance with water safety and safe compressed air policies

Compliance with waste policies

Compliance with hand hygiene and gloving policy.

Compliance with uniform and current PPE policies.

Appropriate staff grades fitted to required respiratory protection and staff records maintained.

Compliance with Occupational Health pre-employment health checks and mandatory vaccination status.

All staff encouraged to have Flu and COVID vaccinations. Aim for minimum of 70% uptake.

Feedback to alerts issued.

ICP concerns and incidents reported are investigated and actioned appropriately and in a timely manner.

Antimicrobial prescribing is safe and appropriate , conforming to current guidance and underpinned by regular audit of antimicrobial use.

Reduce antimicrobial prescribing by 15% over the next 12 months.

Safe actions: Our learning and improvement culture.

All relevant staff to comply with all Continuing Professional Development in ICP and decontamination mandated by professional bodies and BCU: GDC CPD-approved courses on ICP and decontamination
BCU courses: Level 1 and 2 ICP ,ANTT, Donning and doffing. % BCU ICP training compliance must never fall below 85% overall.

Develop IP champions across the service. Aim for 1 champion per service area for each day.

All clinics will complete daily audit checklist, which includes details of daily huddle , uniform and PPE compliance and peer-to peer handwashing.

Staff engagement with data collection and reporting mechanisms.

All staff encouraged to engage with ICP Innovation and QI

All staff to learn from incidents/ experience/events/ local quality improvement initiatives/audits through sharing monthly NWCDS management communications.

The WG Gwên am Byth Older persons' programme will be offered to all care homes. Amongst its aims are risk reduction of sepsis and of pneumonia in this vulnerable population. .

Mouth care for Adults and Children in Hospital (Secondary Care and Community Hospitals). Support will be offered to this WG National Programme whose aims are to reduce the Healthcare Acquired Infection risks of sepsis and of pneumonia, whilst receiving care as in patients.

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North Wales Managed Clinical Services

PURPOSE AND VISION

To improve health and deliver excellent care.

We will improve the health of the population, with particular focus upon the most vulnerable in our society. We will do this by developing an integrated health service which provides excellent care delivered in partnership with the public and other statutory and third sector organisations. We will develop our workforce so that it has the right skills and operates in a research-rich learning culture.

Current Position

Supporting staff, patients and visitors to:-

- Relax and change covid regulations where appropriate to assist in the introduction of a new normal to the organisation – in line with WG recommendations
- Implement government guidance in clinical areas
- Reduce cross infection of Covid 19, C.diff, MRSA etc
- Demonstrate active infection prevention management
- Risk assessments
- Use appropriate ICP, PPE and social distance rules

Aims

Promote positive culture by :-

- Assuring staff and service users of a safe environment in the light of changing welsh government guidance.
- Reinforcing positive actions and maintain best practice, where currently in use
- Staff engagement regarding IPC / PPE champions
- Maintain and monitor mandatory and relevant training
- To include staff and patients in hand hygiene

Actions to Support Future Delivery

- Ensure use of the agreed Covid/IPC checklists across NWMCS
- Updated Covid action cards circulated and in use in radiology
- To ask staff to be vigilant and LFT twice weekly
- To encourage staff to attend for Covid 19 and flu boosters
- Audit the signing and use of IPC cleaning schedules in clinical and non clinical areas
- Nominate IPC/PPE champion on all sites
- Invite patients to use hand sanitiser

Measurements

- Audit
- Department walk around and monitor correct usage of documentation
- Monitor feedback both OTS and via PALS and datix to ensure efficient delivery of the service.

We aim to deliver in line with our values: - Put patients first. Work together. Value and respect each other. Learn and innovate. Communicate openly and honestly.

Women's Directorate

Issue	Decision	Action
❖ **Care bundles**	• There will be 100% compliance with PVC and catheter care bundles to ensure the delivery of safe care to all our patients.	• Completion of DATIX for any device bundle not commenced or completed. • Monthly completion of audits with targeted learning for areas of poor compliance.
❖ **Covid-19**	• Patient safety will be prioritised through adopting zero tolerance to achieving full adherence of IPC standards .	• Full adherence to Covid-19 SOP's • Weekly audits aiming for 100% compliance • Maintain hierarchy of controls prior to visitors accessing clinical inpatient services. • Continued promotion of Covid-19 vaccination to pregnant population across North Wales.
❖ **Environmental cleanliness**	• All users of Maternity and Gynaecology services will receive care in re-furbished clean and de-cluttered clinical areas by the 30.3.2023.	• Refurbishment of bathrooms in Wrexham Maternity unit. • Replacement of entrance/exit doors in the YG Maternity unit. • Monthly peer-review audits by matrons in inpatient & outpatient areas.
❖ **Surgical Surveillance following Caesarean Section**	• All women diagnosed with a wound infection following caesarean section will receive evidence based, consistent treatment and advice .	• Wound infection rates to be maintained at <4% (Wales National CS SSI rate 2018). BCUHB CS SSI rate 2021: 2.4% • DATIX and RCA completed for all women diagnosed with a wound infection. • Care pathway in place for all women who present with a ?wound infection and for women diagnosed with a wound infection.
❖ **Screening for MRSA**	• To explore potential of screening pregnant women who are booked to have an Elective Caesarean Section for MRSA.	• Make contact with Microbiology to assess if they have sufficient work-force and equipment for maternity services to implement MRSA screening for pregnant women booked for elective operative birth.

References

- UK Health Security Agency (2022), *Covid-19 vaccination: a guide on pregnancy and breastfeeding*. Available at Covid-19 vaccination: a guide on pregnancy and breastfeeding - GOV.UK (www.gov.uk) (Accessed: 19 May 2022).

Report title:	Healthcare Inspectorate Wales (HIW)			
Report to:	QSE Committee			
Date of Meeting:	Tuesday, 06 September 2022			
Executive Summary:	This report provides the Committee with an updated position in relation to Healthcare Inspectorate Wales activity for the period June to July 2022			
Recommendations:	The committee is asked to receive this report			
Executive Lead:	Angela Wood, Executive Director of Nursing and Midwifery			
Report Author:	Matthew Joyes, Associate Director of Quality Erika Dennis, Quality Lead Manager			
Purpose of report:	For Noting ☐	For Decision ☐	For Assurance ☒	
Assurance level:	Significant ☐ High level of confidence/evidence in delivery of existing mechanisms / objectives	Acceptable ☐ General confidence/evidence in delivery of existing mechanisms / objectives	Partial ☒ Some confidence/evidence in delivery of existing mechanisms / objectives	No Assurance ☐ No confidence/evidence in delivery

Justification for the above assurance rating. Where 'Partial' or 'No' assurance has been indicated above, please indicate steps to achieve 'Acceptable' assurance or above, and the timeframe for achieving this:	
Steps to achieve acceptable assurance have commenced are noted in the 'HIW Position June – July' of this report.	
Link to Strategic Objective(s):	Quality and Safety
Regulatory and legal implications	Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales.
Details of risks associated with the subject and scope of this paper, including new risks (cross reference to the BAF and CRR)	BAF21-10 - Listening and Learning
Financial implications as a result of implementing the recommendations	N/A
Workforce implications as a result of implementing the recommendations	The Health and Care Standards Wales 2015 takes into consideration staff and resources. HIW can make recommendations in line with the standards.
Feedback, response, and follow up summary following consultation	N/A
Links to BAF risks: (or links to the Corporate Risk Register)	BAF21-10 - Listening and Learning
Reason for submission of report to confidential board (where relevant)	N/A
Next Steps: N/A	
List of Appendices: Appendix A - AmaT Inspection Dashboard at 13.08.2022	

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

Healthcare Inspectorate Wales (HIW) Activity Report to the QSE Committee June-July 2022

Healthcare Inspectorate Wales (HIW) Activity Report to the QSE Committee June-July 2022

INTRODUCTION

Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales who inspect NHS services, and regulate independent healthcare providers against a range of standards, policies, guidance and regulations to highlight areas requiring improvement.

In line with Welsh Government's plan, A Healthier Wales, health and social care must be designed as a whole system, delivered in accordance with quality and safety outcomes, which is central to the work of HIW.

HIW check that healthcare services are provided in a way which maximises the health and wellbeing of people. In addition, they focus on the quality of healthcare provided to people and communities as they access, use and move between services, and adapt their approach to ensure they are responsive to emerging risks to patient safety.

HIW also monitor the use of the Mental Health Act and review the mental health services to ensure that vulnerable people receive good quality of care in mental health services.

HIW are also requested by HM Inspectors of Prisons to provide a clinical review of a prisoner's healthcare if they die in custody.

INTERNAL PROCESS

The Quality Directorate manage the internal HIW process and activity for the Health Board on behalf of the Chief Executive and Executive Director of Nursing and Midwifery via an internal standard operating procedure.

The team are currently reviewing and updating the HIW Protocol for the Health Board. Process mapping exercises have taken place with key colleagues across the Health Board. The draft protocol has been shared on the Health Board's policies consultation page on the intranet and a review of feedback is underway.

Once finalised, the protocol will be submitted for further discussion and ratification in line with our internal process for policies and written control documents.

The protocol will be reviewed annually to account for any improvements and regulatory changes.

IMPROVING ASSURANCE AND DATA

In 2020, the Health Board changed from capturing HIW intelligence via Excel spreadsheets to the DatixWeb patient safety system. More recently, the new cloud based "Once for Wales" DatixCymru

system that has been implemented as of 01 April 2022 does not support HIW activity capture and management.

This led to exploration of alternative options and the new database will be the AMaT system, which was implemented at the beginning of August 2022. AMaT is a well-established audit management and tracking system and is used by NHS bodies across England and Wales. Whilst the Health Board recently implemented the software for clinical auditing, we are one of the first in Wales to use the system's 'inspection module'. However, health boards are collaborating to use AMaT for a wider arrange of clinical assurance and effectiveness functions.

The AMaT inspection module will enable the Health Board to manage all recommendations, information requests, actions and evidence before, during and following an inspection. It provides the following benefits for inspections:

- Real time overview of the progress of all recommendations and actions;
- Improved approval process for actions and evidence of completion;
- Linking themes and regulations to recommendations;
- Timely notifications and overdue alerts to ensure evidence and actions are completed.

This is a positive change as the system will help to improve our ability to triangulate data and provide assurance that we are improving patient care, managing risk, and complying with reporting requirements.

Migration of HIW data from DatixWeb, from 01 April 2022 has taken place and the Quality Directorate is currently 'testing' the system. All HIW activity is now captured and tracked via the AMaT system. Moving forward, the Quality Directorate will support responsible leads with accessing, updating and uploading evidence to the system, as HIW activity is received and inputted into the system.

The committee are asked to note that the Health Board continue to work with the AMaT Super User Group Wales to develop the inspection module further. This includes the embedding of the Health and Care Standards for Wales and the dashboard, to provide clear visuals of our audit data, giving us real-time insight into how well we are performing, and providing the ability to react swiftly to implement change and improvements where necessary.

HIW ACTIVITY – JUNE-JULY 2022

AMaT Inspection Dashboard

Appendix B is a high level report from the AMaT inspection dashboard and provides an initial overview of all HIW activity from 1st April 2022 which has been migrated over from the DatixWeb system.

In relation to the data supplied within this report, the Committee are asked to note the migration of data from DatixWeb to AMaT from 01 April 2022 was only completed just prior to finalisation of this report. Data validation is now underway. Should any inconsistencies be identified, these will be rectified and highlighted in the next report to the committee in November 2022.

For the most recent position, the committee are asked to note the status of the most recent HIW inspection which was undertaken in May 2022 the Emergency Department, Glan Clwyd Hospital (ref: CE22- 840 YGC ED HIW Inspection).

Of the 30 recommendations made to the Health Board by HIW, 139 suggested service improvements were submitted to HIW of which the status is as follows;

- **10 actions (7%) are partially complete**; this means the action has not yet passed the due by date and a progress update has been received and evidence / assurance is pending
- **115 actions (83%) are partially complete (overdue**); this means the action has passed the due date, however a progress update has been received and evidence / assurance is pending
- **14 actions (10%) are overdue;** this means the action has passed the due by date and no progress update, evidence or assurance has been received

This reflects the most recent position at the time of submitting this paper to the committee. In addition, there was a lack of assurance around progress from the initial inspection by HIW in March 2022 (ref: CE22-336 YGC ED HIW Inspection), for which **54 actions remain overdue**.

Whilst the service improvement actions submitted to HIW in March sought to deliver the improvements required, it is clear that they had limited impact and not all had become fully embedded in routine practice by the time of the May inspection.

Therefore, the following steps have been taken and communicated to HIW and Welsh Government for further assurance;

- Actions have been taken since the May report. They include consolidation of the initial actions referred to in the improvement plan submitted to HIW in March
- A review has been undertaken to ensure that moving forward, the service improvements are supported by a clear improvement methodology. This means that the agreed actions are being audited as part of a structured improvement cycle.
- As a result, as changes are made they are subject to audit and review to ensure that they are embedded. Only at this stage would they be considered complete for the purposes of the action plan, this explains why 90% of actions for the May inspection are partially complete and not yet fully complete (approved).

In response to this negative assurance position, the Quality Directorate has worked extensively with the new Improvement Director for Clinical Safety at YGC and the new Programme Director for the YGC Improvement Plan to set out clear expectations for the evidence needed and to support the teams to provide this as actions are completed. This new team have demonstrated a clear grip on the challenges and the work needed. The Quality Directorate will continue to work with the YGC site and the new improvement/programme team to secure assurance, however; evidence will only be accepted where it demonstrates compliance.

National Review - Patient Flow (Stroke Pathway).

The committee are also asked to note the status of CE21-2863 HIW National Review - Patient Flow (Stroke Pathway).

In December 2021, HIW notified the Health Board of it's the National Review. The focus of the review is to gain a greater understanding of the challenges that healthcare services face in relation to how patients flow through healthcare systems, and to test if arrangements for patient flow are robust.

HIW requested;

1. That a self-assessment be completed by the Health Board to help inform their review by 17 January 2022. Subsequently, the information was submitted to HIW.

2. On 8 August 2018, HIW published a report for its thematic review of Patient Discharge from Hospital to General Practice. The review made 13 recommendations for Health Boards to act upon, and HIW requested a response from all Health Boards in relation to their current position for each recommendation, which would inform their Patient Flow review, and may also be published as a national summary. HIW requested the Health Board to provide a response to the recommendations by 4 February 2022.

Patient Discharge from Hospital to General Practice Action Plan

Of the 13 recommendations made in the Patient Discharge from Hospital to General Practice Action Plan submitted to HIW, 6 actions are overdue. The Quality Directorate are progressing these overdue actions with the Programme Director for Unscheduled Care who is ensuring that the action plans aligns with the Urgent and Emergency Care (UEC) Improvement Programme. As above, evidence will only be accepted where it demonstrates compliance.

Glan Clwyd Hospital Inspection

In February 2022, HIW notified the Health Board that an onsite inspection at Glan Clwyd Hospital would take place 9 to 10 August 2022, with the focus of the visit on patient flow concentrating on the stroke pathway, from the point of a patient arriving in an ambulance, or self-presenting at an Emergency Department (ED), through to discharge from hospital or transfer of care to other services. The dates were later changed to 25 – 27 July by HIW due to operational arrangements. No immediate or serious concerns were raised by HIW.

The visit was identified as purely an information gathering exercise and the evidence collated will be analysed in due course and will form part of the national report which will be drafted later this year/early 2023. The report will contain recommendations to Health Boards, Local Authorities and Welsh Government.

The key issue across the whole of Wales is effective discharge of complex patients due to social care issues. This has a negative impact on patient flow through the hospital system through to patients waiting ambulances in the community. HIW are working with our Care Inspectorate Wales colleague in getting a better understanding of those issues which will be highlighted in the report.

Wrexham Maelor Inspection

Additionally, the Committee are advised that HIW undertook an inspection of the Emergency Department, Wrexham Maelor Hospital on 8 – 10 August 2022. No immediate concerns or serious issues were raised however at the time of writing the inspection process remains ongoing via review of clinical documentation. The Health Board await the improvement plan from HIW and in the meantime, the service are taking steps to ensure the initial verbal feedback from the inspection is shared with staff across all sites, and service improvement is commenced.

QUALITY GRAND ROUNDS PROGRAMME – HIW SESSION SCHEDULED

In addition to the reviews undertaken and plans in place, the Quality Directorate have invited HIW to take part in our Quality Grand Rounds Programme in September 2022. HIW will provide a session to Health Board staff in relation to who they are, how they operate and how the Health Board can, in accordance with the Health and Care Standards for Wales, drive improvement.

Further details and information for staff will be featured on the Health Board's intranet page and the Weekly Bulletin closer to the time.

Inspections filtered by

Summary					Actions							
No. of inspections	MD	SD	WN	PIR	In progress	Part. complete	Part. complete (Overdue)	Overdue	Unable to complete	Completed (AA)	Rejected	Completed
17	4/73 (5%)	1/4 (25%)	0	0	1	10	115	79	0	8	0	5

Inspections					Actions							
Title	MD	SD	WN	PIR	In progress	Part. complete	Part. complete (Overdue)	Overdue	Unable to complete	Completed (AA)	Rejected	Completed
CE22- 840 YGC ED HIW Inspection	0/30 (0%)	0	0	0	0	10	115	14	0	0	0	0
CE21-2140 Hergest Unit, MHLD	1/2 (50%)	0	0	0	0	0	0	1	0	0	0	1
CE21-2601 HIW Unannounced Inspection Tan y Coed, Bryn y Neuadd	3/12 (25%)	1/1 (100%)	0	0	1	0	0	0	0	8	0	4
CE21-2863 HIW National Review - Patient Flow (Stroke Pathway)	0/4 (0%)	0/2 (0%)	0	0	0	0	0	6	0	0	0	0

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE22-336 YGC ED HIW Inspection	0/13 (0%)	0/1 (0%)	0	0	0	0	0	54	0	0	0	0
CE22-261 HIW Quality Check, Emergency Department YG	0/2 (0%)	0	0	0	0	0	0	4	0	0	0	0
CE22-603 YG ED Staffing Concerns	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-741 Letter of Concern - Hergest Unit, MHLD	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	**MD**	**SD**	**WN**	**PIR**	**In progress**	**Part. complete**	**Part. complete (Overdue)**	**Overdue**	**Unable to complete**	**Completed (AA)**	**Rejected**	**Completed**
CE22-843 Ysbyty Glan Clwyd, Emergency Department - Service Requiring Significant Improvement	0	0	0	0	0	0	0	0	0	0	0	0
CE22-841 Letter of Concern - Hebog Ward, YG	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-907 Request for Assurance Ablett Unit, Dinas Ward	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
HIW Enquiry Heddfan Unit, Hydref Ward	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0

Inspections					Actions							
Title	MD	SD	WN	PIR	In progress	Part. complete	Part. complete (Overdue)	Overdue	Unable to complete	Completed (AA)	Rejected	Completed
CE22-957 Request for Assurance Ablett Unit, Dinas Ward	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1008 Assurance around ED Staffing YG	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1178 - OFFICIAL SENSITIVE - Emergency Department, Ysbyty Glan Clwyd	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-1177 HIW Assurances Required - WMH- ED	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0
CE22-612 HIW Vascular Concerns	0/1 (0%)	0	0	0	0	0	0	0	0	0	0	0