Bundle Quality, Safety & Experience Committee 20 January 2023

1 OPENING ADMINISTRATION

1.1 09:30 - QS23/01 - Welcome, introductions and apologies for absence - Chair - Information - Verbal

1.2 09:32 - QS23/02 - Declarations of interest on current Agenda - Chair - Decision - Verbal

1.3 09:34 - QS23/03 - Minutes of last meeting – 1 November 2022 - Chair - Decision - Paper

QS23.03 - QSE Minutes 01.11.22 V0.2LR.doc

1.4 09:36 - QS23/04 - Action log - Chair - Decision - Paper

Summary Action Log QSE Public - 1.11.22 - updated 13.01.23.docx

1.5 09:41 - QS23/05 - Patient Story - Executive Director of Nursing & Midwifery - Assurance - Video

QS2305 - APPROVED - QSE - Jan 2023 - Patient Story.docx

2 STRATEGY AND POLICY

2.1 09:51 - QS23/06 - Corporate Risk Register - Associate Director of Governance - Assurance - Paper

Papers too follow

QS2306 - QSE Committee Coversheet - Corporate Risk Register Public v2.2.docx

QS2306 - Appendix 1 - Corporate Risk Register.docx

QS2306 - Appendix 2 - Newly Escalated risks.docx

QS2306 - Appendix 3 - Full List of All Corporate Risk Register Risks.docx

QS2306 - Appendix 4 - Risk Key Field Guidance V2-Final.docx

2.1 10:01 - QS23/07 - Policies for Approval - Lead Executives - Assurance - Paper

• *Consent Policy*

QS2307 - MD01 -Board Committee Coversheet - V2.docx

QS2307 - MD 01 Policy on consent to examination or treatment BT M1.docx

QS2307 - MD 01 EqIA For1.docx

3 QUALITY SAFETY AND IMPROVEMENT

3.1 10:11 - QS23/08 - Mental Health Outcomes and Improvements - Executive Director of Public Health - Assurance - Paper

QS2308 - QSE MHLD Outcomes & Improvements Paper - January 2023 v.08.pdf

QS2308 - Appendix 1 - MHLD Brief QSE January 2023 v.07.pdf

QS2308 - Appendix 2 - Outstanding actions QSE January 2023 v.02.pdf

3.2 10:26 - QS23/09 - YGC Improvement Plan Update - Executive Director Transformation, Strategic Planning, And Commissioning/ Programme Director Clinical Safety Improvement Assurance Paper

QS2309 - YGC QSE Paper 20th January.docx

3.3 10:36 - QS23/10 - Vascular Services Update - Executive Medical Director - Assurance - Paper

QS2310 - 20230120-QSE_Jan_Paper_Vascular.docx

3.4 10:51 - QS23/11 - Urology Improvement Plan Update - Deputy Medical Director - Assurance - Paper

QS2311 - 2023011.UROLOGY QSE January 23.v5.docx

3.5 11:01 - QS23/12 - Patient Safety Report - Executive Director of Nursing & Midwifery - Assurance - Paper

QS2312 - APPROVED - QSE - Jan 2023 - PS Report.docx

3.6 11:11 - QS23/13 - Patient and Carer Experience Report - Executive Director of Nursing & Midwifery - Assurance - Paper

QS2313 - APPROVED - QSE - Jan 2023 - PCE Report.docx

3.7 11:21 - QS23/14 - HIW Update - Executive Director of Nursing & Midwifery - Assurance - Paper

QS2314 - APPROVED - QSE - Jan 2023 - Regulatory HIW-CIW.docx

QS2314a - APPROVED - QSE - Jan 2023 - Regulatory HIW-CIW - Appendix A - HIW Patient Flow (stroke pathway).pdf

3.8 11:31 - QS23/15 - Quality/Safety Awards and Achievements - Executive Director of Nursing & Midwifery - Consent - Paper

QS2315 - APPROVED - QSE - Jan 2023 - Quality Recognition.docx

3.9 11:31 - QS23/16 - Health & Safety Report including HSE update - Executive Director of Workforce and Organisational Development - Information - Paper

QS2316 - 2023_01_20_QSE - Q2 2022 2023 Health and Safety Report V0.3_Final_SG Approved.docx

3.11 11:41 - QS23/17 - Nurse Staffing Act - Executive Director of Nursing & Midwifery - Assurance - Presentation

QS2317 - Nurse Staffing QSE Presentation.pdf

3.12 11:51 - Comfort Break

4 12:01 - REPORTS

4.1 12:01 - QS23/18 - Chair's Assurance Reports from Strategic and Tactical Delivery Groups - Lead Executives - Consent - Paper

1 Strategic Occupational Health and Safety Group
2 Clinical Effectiveness Group
3 Patient and Carer Experience Group
4 Infection Prevention Steering Group
5 Patient Safety & Quality Group

QS2318.1 - 2023_01_20_QSE - SOHSG Nov22 Chairs' Report V0.2_Final.doc

QS2318.2 - 20230112.CEG report QSE January 2023.docx

QS2318.2a - 20230112.Clincal Audit Activity report.Q2.V3.docx

QS2318.3 - APPROVED - QSE - Jan 2023 - PCE Chair Report.docx

QS2318.4 - IPSG Committee Chair's Assurance Report for QSE Jan 23.docx

QS2318.5 - PSQ Chairs Report - Jan 23 MJ review v4.jl.docx

4.2 12:11 - QS23/19 - Infection Prevention Report - Executive Director of Nursing & Midwifery - Consent - Paper

QS2319 - Environmental Cleanliness 1 - QSE (full version).pdf

4.3 12:11 - QS23/20 - Quality & Performance Report - Director of Performance - Assurance - Paper

QS2320 - QSE cover - January 2023 (Nov Position).docx

QS2320a - IQPR_QSE_200123c.pdf

5 12:21 - CLOSING BUSINESS

5.1 12:21 - QS23/21 - Issues Discussed in Previous Private Session - Chair - Assurance - Paper

5.2 12:31 - QS23/22 - Date of Next Meeting - Chair - Information - Verbal

5.3 12:41 - QS23/23 - Exclusion of Press and Public - Chair - Information - Verbal Report

Betsi Cadwaladr University Health Board

Minutes of the Quality, Safety & Experience Committee meeting held on 1 November 2022
Via Teams

Present:

Lucy Reid	Independent Member (Chair)
Cheryl Carlisle	Independent Member
Jacqueline Hughes	Independent Member
John Gallanders	Independent Member
Hugh Evans	Independent Member

In Attendance:

Gareth Evans	Acting Executive Director of Therapies & Health Science
Sue Green	Executive Director of Workforce and Organisational Development
Dave Harries	Head of Internal Audit
Gill Harris	Deputy CEO/Executive Director of Integrated Clinical Services
Matthew Joyes	Acting Associate Director of Quality Assurance
Phil Meakin	Associate Director of Governance
Teresa Owen	Executive Director of Public Health
Philippa Peake-Jones	Head of Corporate Affairs (minutes)
Angela Wood	Executive Director of Nursing and Midwifery
Geraint Parry	Quality Improvement Fellow (for part)
Paul Andrew	Director Of Operations (for part)
Jim Mcguigan	Deputy Director Of Integrated Clinical Delivery (for part)
Sara Hammond-Rowley	Consultant Clinical Psychologist (for part)

Agenda Item	Action
QS22.266 – Welcome, Introductions and Apologies for Absence Apologies were received from Chris Stockport	
QS22.267 Declarations of Interest on current agenda **QS22.267.1** The Executive Medical Director declared an interest in the RCGP report	
QS22.268 Minutes of Previous Meeting Held in Public for Accuracy **QS22.268.1** The minutes of the meeting held on 6 September 2022 were	

approved as an accurate recollection of the meeting subject to the spelling of the last name of the Internal Auditor and the correct title to be used for the Executive Director Transformation and Planning. **QS22.268.2 It was resolved that** the minutes were approved as an accurate record of the meeting held on 6 September 2022	
QS22.269 - Matters Arising and Table of Actions **QS22/269.1** The Committee reviewed the action log and closed actions where appropriate.	
QS22.270 - Patient Story **QS22.270.1** The Committee watched a video on the collection of experiences from staff from WAST and BCUHB Occupational Therapy Service describing the Falls Response Team pilot. **QS22.270.2** Attendees were very supportive of the pilot noting that the sooner it is rolled out across the Health Board the better and that what was key and had not been highlighted in the video was the communication with the family of a patient. The Acting Associate Director of Quality Assurance advised that the family were kept informed. **QS22.270.3** An Independent Member queried where St John's Ambulance featured in the pilot, it was noted that the call handler fields the response. A discussion took place around funding and the Acting Associate Director of Quality Assurance advised that he would respond outside of the meeting. **QS22.270.4** The Chair thanked the team for providing the update but highlighted that it was a service update as opposed to a patient story. She reiterated the purpose of the patient story was to hear the voice of the patient and asked for this to be considered for future updates to the Committee. **QS22.270.5 It was resolved that** the Committee receive and reflect upon the story	MJ
QS22.271 Report of the Lead Executive **QS22.271.1** The Committee received the report of the Lead Executive, it was noted as the quality effectiveness work was undertaken there would be an opportunity to look at the "so what" collectively. **QS22.271.2** An Independent Member queried the level of progress for complaint responses highlighting that there was a 25% response rate rather than 75% response and what would be happening to address this. The Executive Director of Nursing and Midwifery advised that trajectories were being reviewed with a significant improvement taking place moving from the high 400's down to 200's and that these were being reviewed at accountability meetings. The Acting Associate Director of Quality Assurance advised that there should be a	

significant impact by early December. Attendees discussed the quality of responses and the sign off process for each response and how they are measured. It was noted that with regards to Ombudsman referrals the Health Board was in the middle of the pack and in line with the average for Wales. **QS22.271.3 It was resolved** that the Committee received the report.	
QS22.272 Corporate Risk Register **QS22.272.1** The Associate Director of Governance clarified the role of the QSE Committee noting that they had operational oversight and a role to scrutinise the risks presented. It was noted that there was a new section in the report called emerging risks and that the paper highlighted the new risks being proposed. **QS22.272.2** An Independent Member queried the 4/5 Health and Safety Risks and that these were sitting with the Executive Director of Finance. The Chair also challenged the scoring for compliance with contractors risk and whether this should be on the corporate risk register. She said she remained concerned about the lack of clinical risks on the register. The Executive Director of Workforce and Organisational Development reminded the Committee that in 2019 a full gap analysis was undertaken in relation to the 33 pieces of legislation and throughout 2019/20 it was agreed that the delivery against all of the Health and Safety Risks that were solely Estate's risk would be managed through Estates rather than with the Health and Safety Department. The Executive Director of Workforce and Organisational Development concluded that she would be happy to provide all of the Health and Safety Risks should this be necessary. The Chair queried the mitigations in place as she would have expected the risk scores to be reducing. **QS22.272.3** The Deputy CEO/Executive Director of Integrated Clinical Services advised that the Associate Director of Governance and his team were working with the leads to refresh the register and stepping up the Risk Management Group. It was noted that the IHC's are reviewing and challenging the risks and mitigations. **QS22.272.4** The Interim Board Secretary advised that at the last RMG meeting a Health and Safety Report had been received and that one of the actions taken was to make violence and aggression and ligature corporate risks. **QS22.272.5** The Chair queried the number of policies referenced in the action updates stating they were going to the Committee but had not been presented. The Associate Director of Governance clarified that the newly established HBLT would do some harmonising of the risks and identified Health and Safety Risks will need to be taken to RMG. **QS22.272.6** An Independent Member highlighted that Safeguarding Forums were not taking place and the Deputy CEO/Executive Director of Integrated Clinical Services advised that she would take the matter outside of the meeting. **QS22.272.7** A query was raised by an Independent Member around the Welsh Risk Pool's tolerance regarding non-compliance with regards to claims and the	GH

Acting Associate Director of Quality Assurance advised that reimbursement was generally subject to learning and that a case management report would be submitted detail around the national procurement platform were shared. **QS22.272.8** The Chair thanked the Associate Director of Governance for a more succinct report but noted that more clinical risks were required. It was noted that risk owners needed to update the risks. The Chair also highlighted that the need to review the legionella risk as it was particularly concerning if management considered that despite the controls in place, the organisation was unable to prevent a legionella outbreak. It was noted that this would be picked up by the Strategic Occupational Health and Safety Group (SOHG). **QS22.272.8** The Committee discussed mandatory training and the Executive Director of Workforce and Organisational Development noted that mandatory training would be reviewed to address non clinical contact employees. **QS22.272.9 It was resolved** that the Committee reviewed and discussed the report.	SG
QS22.273 Polices for Approval **QS22.273.1** The Committee approved the Thromboprophylaxis Policy noting that it was currently in Draft and was an All-Wales Policy. **QS22.273.2** The Committee were content with the IPC Policy but noted the EQIA was missing and that subject to that being circulated outside of the meeting the policy would be approved.	
QS22.274 Mental Health Outcomes and Improvement **QS22.274.1** The Executive Director of Public Health welcomed Paul Lumsdon, Interim Director of Nursing, to the meeting advising that progress was being made and that the service was an improvement journey. The Interim Director of Nursing advised that he would review the papers and appendices and look at how these should be summarised now that programme governance was aligned. Staff engagement and leadership capacity were highlighted noting that a matrix approach with regards to quality improvement and service development is being taken forward but that the transformation would take some time. Short, medium, and long term goals will be identified and reported back to the committee. **QS22.274.2** Independent Members advised that the Gant charts would need to be updated for the next meeting and a sense of what has changed, where the problems are, what is proving difficult and where the risks lie would need to be clear with concerns around capacity identified. The Executive Director of Public Health shared the concerns about capacity, noting that the new Head of Strategy starts in December which should increase momentum. **QS22.274.3** The Interim Director of Nursing advised that there was a need to refine where progress has been made without taking away detail and that this would be picked up in future updates.	

QS22.274.4 The Executive Director of Workforce and Organisational Development advised that the recruitment for a permanent Director of Mental Health and a Director for Nursing would commence shortly and that she recognised that there was an outstanding retrospective piece of work around Hergest NOC needed to be triangulated across to other Committees agreeing that restraint practice needed to be reinvigorated and come back to both MHACC and QSE. **QS22.274.5** Attendees discussed the restraint practice report noting that there was a lot of work to do. The Interim Director of Nursing advised that the permanent advisement was really welcomed and that there needed to be a shift from interims to permanent staffing, he agreed that the restraint work was a large piece of work that would need to be returned to Committee. **QS22.274.6** The Executive Director for Public Health advised that the Operating Model for the Division had returned to ET and that final changes were being made to confirm the structure. **QS22.274.7** The Chair asked for clarification that the five concerns raised in the HIW report were being fed into the improvement work. It was noted that better attention is being given to evidencing actions whilst noting that Hergest was still very fragile and that there was a need to wrap the team around Hergest. **QS22.274.8** The Interim Director of Nursing advised that he would prepare the next report for the Committee based on feedback given within the discussions. **QS22.274.9 It was resolved** that Committee reviewed the proposed update on the development of the MH&LD Divisional Improvement Plan.	PL
QS22.275 YGC Improvement Plan [Geraint Parry and Paul Andrew joined the meeting.] **QS22.275.1** The Deputy CEO/Executive Director of Integrated Clinical Services advised that although a lot of work had been done there was more to do and that the team were working with both WOD and the OMD with regards to medical leadership. **QS22.275.2** The Committee were informed that a stronger foundation was in place with Geraint Parry and Paul Andrew in post and noted that embedding practice is essential. Launch events had taken place with staff and there had been the start of an Integrated Medical Board with real engagement from the medical leaders with the vision of how to get MDTs working while learning from each other. **QS22.275.3** An Independent Member advised that it was essential to be realistic with the approach but was positive with the response that has been seen so far and that there were challenges at YGC that would make it difficult for the perception for improvement but that Cabinet was focussed on the right	

conversations and that the programme was in as good a place as could be expected at that time. **QS22.275.4** An Independent Member raised the two outstanding actions with regards to children and young people noting that two weeks ago the children and young people event took place and that support from Improvement Cymru representative has been sought and will engage with colleagues from ED, Paediatrics to identify training needs. **QS22.275.5** A discussion took place around reducing 12 hour stays and ensuring that this was not being done at the expense of anything else. It was noted that the cogs are being looked at both for 12 and four hour average waiting time to ensure that everyone is being looked at equitably and that overall the waiting time had been improving but not at the cost of something else. **QS22.275.6** The Committee discussed the concern around safety huddles noting that HIW had reported an inconsistent approach. Proposals had been submitted to ensure that the team take clinical ownership of these. Attendees discussed locum staffing handovers and the protocols in place. **QS22.275.7** The Committee discussed the targeted recruitment campaign noting that the work was focusing on the areas where there are significant hot spots, noting that this could either be a department or a type. This work was ongoing with the workforce team with the second element being that people do want to move and how this is supported without creating a risk. The Executive Director of Workforce and Organisational Development advised that a detailed report was being presented at Cabinet with recruitment and retention being two elements. [Geraint Parry and Paul Andrew left the meeting.] **QS22.275.8 It was resolved** that the Committee noted the progress made to date on the YGC Improvement Plan.	
QS22.276 Vascular Improvement Plan **QS22.276.1** The Committee noted that the Vascular Improvement Plan was drafted in the old format but that it was being updated in line with the YGC Improvement Plan, but that this would be done following the imminent HIW inspection in December. The updated plan will be received at the Vascular Steering Group. **QS22.276.2** The Executive Medical Director gave an update on what was being received at the Steering Group noting that a deep dive into amputation rates and associated mortality was being undertaken and that it was showing no room for complacency but that the health board was not an outlier. The Committee were informed that the EPRR response that had been in place to manage rotas had been stood down the previous week. The Committee noted that MDTs reviews would continue to take place with Stoke but that dual operating had not needed to be used.	

QS22.276.3 It was resolved that the Committee: • Noted the progress in the vascular improvement plan and the imminent move to using a maturity matrix to monitor progress. • Noted the progress which has been made to stabilise the consultant workforce, improve the clinical leadership of the service and further develop relationships with peer services. • Noted the assurance arising from longitudinal clinical outcome data. • Noted that current Emergency, Preparedness, Resilience and Response (EPRR) framework was stood down the previous week (but that it would remain as an option if the situation becomes more fragile). • Noted the review of vascular services by Healthcare Inspectorate Wales is now due to take place in December 2022. • Noted the issue of a Prevention of Future Deaths report following an inquest into the death of a patient with ischaemic lower limbs.	
QS22.241 Urology Improvement Plan This item was withdrawn.	
QS22.242 Quality and Performance Report This paper had not been provided to the Committee.	
QS22.279 Patient Safety Report **QS22.279.1** The Chair was grateful that the near misses had been included in the paper this time but asked what the process for learning was and that this would need to be identified going forward. The Acting Associate Director of Quality Assurance noted that this would be included in future reports as well as themes organisationally. The Executive Director of Nursing and Midwifery advised that she was looking to have an organisational learning review meeting, the learning of which would be shared with QSE. **QS22.279.2** The Chair highlighted the references in the report to incomplete documentation as a cause of the incident and wished to reiterate, again, that it was important that if a process was not followed it was understood why this had happened. A discussion took place around the WHO checklist work that had been commissioned and it was agreed that the Committee would undertake a deep dive session on this work and that as part of this approach a review on how success was being measured would be included. **QS22.279.3** The Acting Associate Director of Quality Assurance advised that he would share the information outside of the meeting with regards to the HMP Berwyn death in custody.	PPJ MJ

QS22.279.4 Attendees discussed overdue incidents and the Executive Director of Nursing and Midwifery advised that she would be applying the same rigour to complaints as to incidents. She shared the induction protocols for agency and bank staff and highlighted that the bulletins would be the repository of information. **QS22.279.5 It was resolved** that the Committee received the report.	
QS22.280 Human Tissue Act Inspection Report **QS22.280.1** The Executive Medical Director presented the report highlighting the findings of the inspection. The Chair noted the areas of non compliance that had been identified in the inspection and expressed concern that the Committee had been provided with assurance in December 2021 that appropriate actions had been taken in response to the Maidstone and Tunbridge Wells case. The Executive Medical Director and Deputy CEO/Executive Director of Integrated Clinical Services advised that further understanding was required to understand the background to this. **QS22.280.2** The Executive Director of Workforce and Organisational Development advised that there was a debate around whether or not the recommendations were required as a professional security review had been undertaken and it should not have needed to come to the Committee. The Chair advised that the Committee were assured at the time that the recommendations arising from the review in December 2021 were being taken forward. She reminded the Committee that specific assurance had been requested from an Independent Board Member at the time and this was followed up by a report from the Patient Safety and Quality Group about mortuary security. The Executive Director of Workforce and Organisational Development advised that she have to review who gave that assurance. **QS22.280.3** The Chair also queried reference in the report to the current security risk score for Ysbyty Gwynedd as being 20, which according to the Risk Management Policy would mean it should have been escalated onto the Corporate Risk Register. The Executive Director of Workforce and Organisational Development responded that it was not 20. The Board Secretary advised that the license holder needed to be looped into the Corporate Governance and that a decision as to who the license holder should be going forwards, it was suggested that it should be a member of the HBLT. **QS22.280.4** It was noted that in one of the appendices a number plate was clear and this would be removed from the public domain. **QS22.280.5 It was resolved** that the Committee noted the response to HTA inspection findings / progress with security review.	NL/MM PPJ
QS22.281 HIW Update The Chair welcomed a much clearer report although was unsure about what the appendix referring to 0's meant. The Acting Associate Director of Quality Assurance advised that the 0 referred to a partially complete action, he noted that	

he had been to YGC and had gone through the March inspection report and was content to close off 50% but the remainder lacked evidence, some of this was about the sitet not updating the evidence rather than it not having taken place. **QS22.244.4 It was resolved** that the Committee noted the report.	
QS22.282 Quality/Safety Awards and Achievements **QS22.282.1 It was resolved** that the Committee received the report on Quality/Safety Awards and Achievements and attendees were asked to raise any questions outside of the meeting.	
QS22.284 Sepsis Review **QS22.284.1** The Committee received the report noting that this had been a learning exercise. Risks were discussed and it was suggested that this should be included in the risk relating to management of the deteriorating patient.	
QS22.285 HMP Berwyn **QS22.285.1** The Committee noted that the report was a Prison Inspectorate Report not a HIW Inspectorate Report. Concern was raised with regards to what was identified as urgent for both dental and GP appointments and the Deputy CEO/Executive Director of Integrated Clinical Services advised that she would follow up on this outside of the meeting.	GH
QS22.286 RCGP Report [Jim Mcguigan has joined the meeting.] **QS22.246.1** The Executive Medical Director raised a declaration of interest in that his ex-wife had been the author of the RCGP report but was no longer involved. **QS22.246.2** The Deputy Director of Integrated Clinical Delivery advised that he has a series of meetings with RCGP scheduled and that there was further work to do that would be report back into QSE. **QS22.246.3 It was resolved** that the Committee noted the findings of the report and the proposed next steps.	
QS22.287 GP Out of Hours **QS22.287.1** It was noted that the presentation was shared late the previous evening given the recent working on the project, however, it was shared late given the pressures in the system. The Deputy Director of Integrated Clinical Delivery advised that the action plan attached set out dates that are being worked through. The Deputy CEO/Executive Director of Integrated Clinical Services thanked the team for the significant progress being made in this area and noted the commitment to bring out of hours under Primary Care giving the full benefit of the integrated systems.	

QS22.287.2 A further report will return to the Committee in due course.	
QS22.288 - Psychological Interventions (including Psychological Therapies) for Children and Young People [Sara Hammond-Rowley joined the meeting.] **QS22.288.1** The Consultant Clinical Psychologist shared the the baseline mapping data collection and gaps and challenges these being around data systems, KPI's and reliable data and workforce recruitment, retention and training. It was noted that there were things that were being done really well, that there is a wide range of different interventions and therapies with a great relationship with Bangor University, and close working with Local Authorities and that there were pockets of excellent practice aligned with hearing the voice of Children and Young People. **QS22.288.2** The Committee thanked the author for a comprehensive report noting the concern around capacity to deliver and the reliance on partners. The Chair requested that a similar report focussing on adults be received by the March QSE meeting.	
QS22.289 - Ophthalmology Update (how we are managing the risk stratification) The Deputy CEO/Executive Director of Integrated Clinical Services presented the report noting that she would like the deep dive to have the full oversight of the Interim Director of Regional Delivery. Independent Members thanked colleagues for the speed that this was being addressed and queried any movement on the paediatric service with the Deputy CEO/Executive Director of Integrated Clinical Services advising that she would update on that outside of the meeting. Independent Members queried the Abergele site noting the cleanliness issue and were advised that this had been picked up. Further discussions took place around the Estate Strategy noting that until it had been received it would be difficult to answer whether concerns around the Abergele site had been addressed. **QS22.289.1 It was resolved** that the committee support: • Instigating an Ophthalmology steering group focusing on secondary care service • Aligning the work to the eye care collaborative • Reviewing the risks associated to the service across North Wales	
QS22.291 Chair's Assurance Reports **QS22.291.1** Chairs Assurance reports were received noting that the SOHG had not met and that CEG would be picked up at the forthcoming MHACC on Friday.	
QS22.292 Public Interest Ombudsman Report **QS22.292.1** The Committee received the report noting that it included another	

action plan and that this was essential to share evidence and close once it is submitted. It was noted that most actions are transactional with findings being shared with the Walton Centre with the only action outstanding being to review the complaints process which an All-Wales response is pending.	
QS22.255 Date of next meeting **QS22.255.1** It was noted that the next QSE Meeting would be held on 20 January 2023.	
QS22.256 Exclusion of Press and Public **QS22/256.1 It was resolved that** representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960.	

	BCUHB QUALITY, SAFETY& EXPERIENCE COMMITTEE - Summary Action Log Public Version				
	Officer/s	**Minute Reference and summary of action agreed**	**Original Timescale**	**Latest Update Position**	**Revised Timescale**
	4th May 2021				
1	~~L Brereton~~ M Marcu P Meakin	**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 2021	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. At the time of writing the Policy is scheduled to be circulated by the end of this week. The policy will be signed off through the Executive Team. Suggest close	
	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. CS has discussed this with the Performance Team and this is being picked up within the current re-working of the report.	

				Not closed The outgoing Director of Performance advised that she could confirm that currently GP access and GP OOH data is captured in the Board Report under the Primary and Community Care chapter. Suggest close	
	6 September 2022				
3	P Meakin	**QS22.237 Corporate Risk Register** Review the risk paper to include target risk dates and flag when they would not be met, note and feedback to the RMG that the report could only give the committee partial assurance.		PM discussed this at the RMG in October 2022 and in principal it was agreed as an enhancement to the RM process. There is a report going to the RMG on 4 December to propose to finalise implementation from 1 January 2023 On QSE Agenda Suggest Close	
4	A Wood	**QS22.242 Quality and Performance Report** AW to look into the pathway and identify issues in relation to the declining position for young diabetic people.	January	As this is a new measure, the Performance Team are undertaking a deeper look into the issue and plans, and will report back for the January meeting of the Committee.	
	1 November 2022				

5	MJ	**QS22.270 - Patient Story** MJ to clarify the funding for the patient falls work.		Information requested	
6	PM	**QS22.272 Corporate Risk Register** PM to feed back into the RMG the discussions around policies identified in the paper not having been received at QSE and wider discussions on H&S policies plus the need for more clinical risks to feature		On QSE Agenda Suggest Close	
7	GH	**QS22.272 Corporate Risk Register** GH to follow up on the Safeguarding Forums not currently taking place as identified to CS by CC.		Information requested	
8	SG	**QS22.272 Corporate Risk Register** SG to feedback to the falls group around mandatory training being required to be undertaken by those who have no clinical contact.		**Update 09.01.23 -** This competency has been added to all staff, including non-clinical staff, mandatory training records and the current compliance (December 2022) for Level 1A Prevention of Adult In-patient falls is 80.22% across BCUHB. Suggest close	
9	AW	**QS22.273 Polices for Approval** Circulate the EQIA for the IPC Policy to enable Policy to be approved		Circulated and live Suggest close	

10	PL	**QS22.274 Mental Health Outcomes and Improvement** PL to take the feedback from the discussions forward in a new style of report when presenting to QSE.		An updated paper is on the agenda Suggest close	
11	GP	**QS22.275 YGC Improvement Plan** Geraint Parry agreed to confirm that contact details for Locum's are being shared to ensure that there is the ability to contact them in an emergency or for clarity around their prescribing once their shift is over.		This was confirmed by email on 1/11/22 Suggest close	
12	AW	**QS22.279 Patient Safety Report** Undertake a QSE deep dive on the WHO check list using the same methodology as used for the Workforce Deep Dive and undertake a risk review at the same time.		A meeting date is being identified in April, the matter has been discussed with the Chair and Executive lead and a pre-meeting is also being arranged. Suggest close	
13	GH	**QS22.279 Patient Safety Report** To consider how best to approach the QSE deep dive with the Executive.		It was agreed at Board that the Deep Dive would follow the same methodology as per the Workforce Deep dive which took place with members of PPPH Suggest close	
14	NL	**QS22.280 – Human Tissue Act**		This Matter is being considered	

		Consider who should be the licence holder a HBLT member or an Executive.			
15	PPJ	**QS22.280 – Human Tissue Act** Remove appendix 3 from the public given there is an identifiable number plate in the report.		This has been removed and sent back to the author for redaction. Suggest close	
16	GH	**QS22.285 - Her Majesty's Inspectorate of Prisons** GH to follow up on when an appointment both GP and dentistry becomes urgent.		Info circulated by email on 2/11/22 to QSE members. Suggest close	

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

Teitl adroddiad: ***Report title:***	Patient Story			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	A patient story is presented to the Committee to bring the voice of the patient directly into the meeting. The digital patient story will be played at the meeting. A short summary is included in the attached paper.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Rachel Wright, Patient and Carer Experience Lead Manager			
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:***
In line with best practice, the patient story is presented to the Committee; 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.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
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	BAF21-10 - Listening and Learning

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***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
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) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Patient Story Summary	

Betsi Cadwaladr University Health Board
Patient Story: Pulmonary Embolism

A video story told by Catrin will be played at the meeting.

Overview of Patient Story

Catrin shares her experience through diagnosis and treatment of Pulmonary Embolisms (PE) in Ysbyty Glan Clwyd.

I am 33 years old and I attended A&E in Ysbyty Glan Clwyd where a scan confirmed I had a Pulmonary Embolism and I had multiple clots on both lungs. I was not advised of the symptoms, how long they would occur, how this could be treated in the long term and how it would impact on my life.

I received no information on how I can support myself with this condition. The only information I found was on Google. I had no one to speak to about my concerns, I was so lucky to receive the support from the Deep Vein Thrombosis (DVT) Nurses. The DVT Nurses went above and beyond to support me and my family.

Summary of Learning and Improvement

Discussions have taken place between the Lead Thrombosis Specialist, Head of Nursing (Medicine) and Consultant, around expanding the Pulmonary Embolism Service for patients following this story.

A pre-audit has been undertaken to capture Pulmonary Embolism patients who have been discharged without follow up intervention from the DVT Team. As part of the audit, the Patient and Carer Experience Team contacted 16 patients to ask a series of questions regarding their care. Following this, the DVT team have implemented improvement interventions for PE patients, which will be continued for two months. After which a post-audit will be carried out to assess the impact of the interventions on patients and the DVT service.

The interventions include:

- The identification via Synapse (IT system) of those who have received the diagnosis of a PE, to enable an accurate targeting of services.
- This is followed by a telephone contact by a DVT nurse to the patients home, to offer advice and support if required, including signposting for anticoagulation therapy. This will continue for a two-month period post discharge.

Whilst the DVT team have seen a dramatic rise in referrals post COVID-19, the capacity within the team is challenging. It is anticipated that the post intervention audit will be positive, which will then support a business case for a permanent Pulmonary Embolism Service for patients.

Opportunities for learning have been identified and actions are in place. The Lead Thrombosis Specialist has arranged for the DVT Team to work alongside Emergency Department staff for two weeks in January 2023 to teach them about anticoagulation.

Further improvement plans include:

- The delivery of in-house trainings sessions by the Lead Thrombosis Specialist Nurse within the Emergency Department (to commence January 2023). This will include anticoagulation therapy and its indications, and a greater awareness of how a patient may feel post diagnosis.
- The DVT Team are working on a Patient Information Leaflet, to include their contact details for follow up and support. This will pass through the Readers Panel (which is a multiagency panel of professionals who scrutinise literature to ensure it is line with Health Board standards and is accessible to all).

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

The Patient and Carer Experience Team extend their gratitude and appreciation to Catrin for sharing her experience.

Teitl adroddiad: ***Report title:***	Corporate Risk Register Report
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023
Crynodeb Gweithredol: ***Executive Summary:***	The Quality, Safety and Experience (QSE) Committee will maintain oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition, it has the ability to scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy. At the last meeting the Committee asked that some additional focus be given to the identification, assessment and management of clinical risks. The purpose of this agenda item is to highlight and to note the progress on the management of the Corporate Risk Register (CRR) and any risks that are emerging or being escalated. The scheduled Risk Management Group meeting which was due to be held on the 6th December 2022 was cancelled and in accordance with good governance the Health Board Leadership Team have received the RMG reports and approved the Risk Management Group papers and recommendations after a period of time allowed for review. In addition, this report gives an update of the proactive work that is being undertaken by the Risk Management Team and Quality Directorate to lever the New Operating Model Governance so as to enable a golden thread of Risk Management embedded into the BCUHB Operational Governance. Furthermore, the report evidences that this is being used to identify, assess and manage clinical risks and risks to workforce (that impact on our services to Patients) The report asks the Committee to review and discuss the report. And to consider and support the proposal to undertake a review of selected “clinical risks” and their controls and actions at the QSE Committee in order to embed this approach.
Argymhellion: ***Recommendations:***	The Committee is asked to: 1. Review and discuss the report and agree changes in risk ratings.

<table>
<tr><td></td><td colspan="4">2. Consider and support the proposal to undertake a review of selected “clinical risks” and their controls and actions at the QSE.</td></tr>
<tr><td>Arweinydd Gweithredol:

Executive Lead:</td><td colspan="4">Nick Lyons, Executive Medical Director</td></tr>
<tr><td>Awdur yr Adroddiad:

Report Author:</td><td colspan="4">Phil Meakin, Associate Director of Governance and:
Anthony Hughes, Risk Assurance Manager</td></tr>
<tr><td>Pwrpas yr adroddiad:

Purpose of report:</td><td>I’w Nodi
For Noting
☐</td><td colspan="2">I Benderfynu arno
For Decision
☐</td><td>Am sicrwydd
For Assurance
☒</td></tr>
<tr><td>Lefel sicrwydd:

Assurance level:</td><td>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</td><td>Derbyniol
Acceptable
☒
Lefel gyffredinol o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

General confidence / evidence in delivery of existing mechanisms / objectives</td><td>Rhannol
Partial
☐
Rhywfaint o hyder/tystiolaeth o ran darparu'r mecanweithiau / amcanion presennol

Some confidence / evidence in delivery of existing mechanisms / objectives</td><td>Dim Sicrwydd
No Assurance
☐
Dim hyder/tystiolaeth o ran y ddarpariaeth

No confidence / evidence in delivery</td></tr>
<tr><td colspan="5">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:</td></tr>
<tr><td colspan="2">Cyswllt ag Amcan/Amcanion Strategol:

Link to Strategic Objective(s):</td><td colspan="3">See the individual risks for details of the related links to Strategic Objectives.</td></tr>
<tr><td colspan="2">Goblygiadau rheoleiddio a lleol:

Regulatory and legal implications:</td><td colspan="3">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.</td></tr>
<tr><td colspan="2">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?</td><td colspan="3">No</td></tr>
<tr><td colspan="2">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?</td><td colspan="3">No</td></tr>
<tr><td colspan="2">Manylion am risgiau sy'n gysylltiedig â phwnc a chwmpas y papur hwn, gan</td><td colspan="3"></td></tr>
</table>

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 were scheduled to meet on the 6th December 2022 to scrutinise the risks. Following the cancellation of the Group the Health Board Leadership Team have approved the papers and recommendations.
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 7th February 2023, therefore an updated position of the risks will be presented during the Quality, Safety and Experience Committee on the 7th March 2023.	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix 1 – Full Corporate Risk Register Report. Appendix 2 - Newly Escalated Risks. Appendix 3 - Full List of All Corporate Risk Register Risks, including Executive Lead and Current Risk Score. Appendix 4 - Corporate Risk Register Key Field Guidance/Definitions of Assurance Levels.	

Quality, Safety and Experience Committee
20th January 2023
Corporate Risk Register Report

1. Introduction/Background

1.1 The Quality, Safety and Experience (QSE) Committee maintains oversight of the operational arrangements to ensure the BAF and risk register are robustly maintained. In addition, it has the ability to scrutinise and challenge the delivery of mitigations against specific risks, whilst holding to account risk owners for non-delivery of action plans or variation from the provisions of this strategy.

1.2 The purpose of this agenda item is to highlight and to note the progress on the management of the Corporate Risk Register (CRR) and any risks that are emerging or being escalated. The scheduled Risk Management Group meeting which was due to be held on the 6th December 2022 was cancelled and in accordance with good governance the Health Board Leadership Team have received the RMG reports and approved the Risk Management Group papers and recommendations after a period of time allowed for review.

1.3 The CRR enables the Board to fulfil its obligations of ensuring there are effective and comprehensive systems and processes in place to identify, understand, monitor and address current and future risks deemed high enough to negatively impact on the delivery of operational objectives, whilst evaluating the effectiveness of their controls, and monitoring associated action plans.

1.4 In addition, this report gives an update of the proactive work that is being undertaken by the Risk Management Team to lever the New Operating Model Governance so as to enable a golden thread of Risk Management embedded into the BCUHB Operational Governance. Furthermore, the report evidence that this is being used to identify, assess and manage clinical risks and risks to workforce (that impact on our services to Patients)

1.5 Since the last report the Operational Governance for key parts of the BCUHB New Operating Model has been introduced and this has given added opportunity to embed the objectives identified in paragraph 1.1 above. This report can evidence that this is having a positive impact on the identification and assessment of clinical risks and risks that impact on the delivery of the services we offer to Patients. (Para 2.9 below)

2. Key Highlights from the December 2022 Risk Management Group

2.1 The Risk Management Group were due to meet on the 6th December 2022, following the cancellation of the meeting, and, in accordance with the required governance to progress risks, the Health Board Leadership Team were requested to review and approve the Risk Management Group papers, recommendations and proposals in relation to the updating of the risks on the Corporate Risk Register. As the Risk Management Group meeting was cancelled no “deep dive” into a Corporate Risk was undertaken, this will be carried out at the next Risk Management Group which is scheduled for the 7th February 2023.

Meetings will be arranged with the risk leads to update the risks in line with the next Risk Management Group meeting which is scheduled for the 7th February 2023.

2.2 Following discussion and support at the Risk Management Group during 2nd August 2022, risk CRR20-06 'Management of Patient Records' is now being split into 3 separate risks. Revised risk for 'Retention and Storage of Patient Records' (CRR22-32) has been developed, and was approved for inclusion on the Corporate Risk Register at the 4th October 2022 Risk Management Group. A second of the three proposed revised risks has further been developed and included on the Corporate Risk Register following the approval from the Health Board Leadership Team 'Risk of Lack of access to clinical and other patient data' (CRR23-33). Work remains ongoing to develop the 3rd revised risk 'Risk of poor clinical recording of patient information', which will include the transfer over of open actions from the current CRR20-06 and result in the closure and archiving of the current Corporate Risk CRR20-06 'Management of Patient Records'

2.3 During the Risk Management Group meeting on the 2nd August 2022, it was noted that risk CRR20-05 'Timely access to Care Homes' 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 has taken place 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.

2.4 During the Risk Management Group meeting on the 4th October 2022 the ophthalmology service proposed to disaggregate risk CRR20-08 'Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients' by the clinical conditions which will enable the risks to reflect impact on patient safety/care by the clinical conditions. Work has taken place to review and re-write the risk, with 5 new risks approved to replace the current CRR20-08.

2.5 The following risks have been incorporated onto the Health Board's risk register and following Executive approval and presentation at the Risk Management Group have been included onto the Corporate Risk Register (Appendix 2).

- CRR23-34 – There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.
- CRR23-35 – Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.

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

- 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.
- CRR23-36 - Cost of Living Impact on Staff and Patients.
- CRR23-37 - Targeted Intervention.
- CRR23-38 - Workforce.
- CRR23-39 - Patient Flow - Impact on Access and Quality of Care.

2.7 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)	33	0	9	1
Tier 2 (9-12)	319	97	36	100
Tier 3 (1-8)	218	52	43	89

3. Strengthening The Management of Risks

3.1 As mentioned in the introduction the BCUHB Risk Management Team have undertaken work to strengthen the management of risks in the Health Board. Some examples are given below:

- Following the approved Risk Management Strategy, the Risk Management Team has developed the RM02 Document ready for approval at the next RMG meeting. This is the document that provides the procedures and processes behind the Risk Management strategy.
- On-going support with risk leads to review their risks in the Integrated Health Communities (IHCs) context. Please see section 4 for more information on this.
- Review of risk training records and database to identify training for risk handlers and managers who require a refresher. There will be a focus on training teams.
- Targeted training for those colleagues identified by their IHC's is underway.
- The Risk Management Corporate Orientation, will now be recorded for new starters to the organisation from February 2022.
- All recommendations from the NHS Wales Audit and Assurances Services have been actioned and signed off by Interim Chief Executive
- Work is also well 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. It has now been agreed that BCUHB will pilot this on behalf of all Health Boards in Wales and this has been warmly received by the Shared Service Partnership.

4. Increasing Focus on Clinical Risk

4.1 Under the Risk Management Strategy, the QSE Committee has a role to focus on risks relating to the Quality and Safety of services that the Health Board provides and at the last meeting there was a request from the Committee that there be a sharpened awareness of "clinical risks" and the ability of the risk management process to identify, assess and manage those risks. This part of the report seeks to provide consideration of this request and a recommendation for the QSE to consider arising from section 4.5 below.

4.2 The next Risk Management Group for February 2023 has a strong clinical focus. In addition to the routine review of the Corporate risks and identification of emerging risks there are specific agenda items on specific clinically focussed agenda items. These are:

1. Secondary Care - East
2. Secondary Care – West
3. Cancer
4. MHLD

4.3 The management of clinical (and non-clinical) risk within the Services Governance structure has been considered in the delivery of the New Operating Model Governance. The following has been agreed and is in place from December 2022 for the three IHCs, Mental Health and Learning Disability Service and Women's Services. Cancer and diagnostic services and Primary Care service is part of a phase 2 to commence from February 2023.

- Service Leadership Teams will have Risk Management item on every Service Leadership Team Agenda and in their newly developed 4 x Service Groups Agenda. **This has now been agreed and is in place from December 2022.**
- Accountability Reviews - Service Leadership Teams to have Risk Management agenda item. Associate Director of Governance to triangulate this information and Risk Management to HBLT at least every two months. **This has now been agreed and has been in place from October 2022.**
- Services to attend BCUHB Risk Management Group. **This is in place from October 2023**
- Furthermore, the Associate Director of Governance triangulates the risk reports from these sources in a report for Health Board Leadership Team to consider in-between the bi-monthly Risk Management Group meetings. As a result of this work there are risks in this report that have been recently escalated using this method. These are risks

CRR23-36 - Cost of Living Impact on Staff and Patients (has a clinical focus)
CRR23-37 - Targeted Intervention. (has a clinical and non-clinical focus)
CRR23-38 - Workforce.(has a clinical impact)
CRR23-39 - Patient Flow - Impact on Access and Quality of Care.(has a clinical impact)

4.4 The “Duty of Quality” legislation means NHS organisations and Welsh Ministers have a duty to:

- create a culture of quality within organisations
- focus on improving the quality of health services and outcomes for the population on an ongoing basis
- actively monitor progress of improvement and routinely share this information with their population

The Associate Director of Quality has convened monthly meetings from January for an implementation and oversight group and this will have provision for “Risk” on the agenda. By its nature this will be a clinical risk focus. The Associate Director of Governance will also be at this group and can oversee the plans related to risk.

4.4 There is now an Executive Delivery Group for Quality that has been established and it will have associate sub groups where risks related to Patient Safety can be considered in some detail. This provides a link between the clinical risks identified in the Incident Reporting System and associated deep dives and the Executive Delivery Groups (EDG). It is therefore proposed that “Clinical Risks” be a standing agenda item at the EDG. The EDG can then report it’s risks to the Risk Management Group – thus allowing for the *golden thread* of Clinical risk through the Governance structure. Furthermore, QSE could seek assurance on this process by requiring a special focus on a specific risk or the process and their mitigations and actions to be considered at the QSE Committee if so desired. This is in line with the role of QSE in the BCUHB Risk Management Strategy. The QSE Committee is asked to consider and support this approach in the recommendations on the cover page of this report.

5. Budgetary / Financial Implications

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

6. Risk Management

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

7. Equality and Diversity Implications

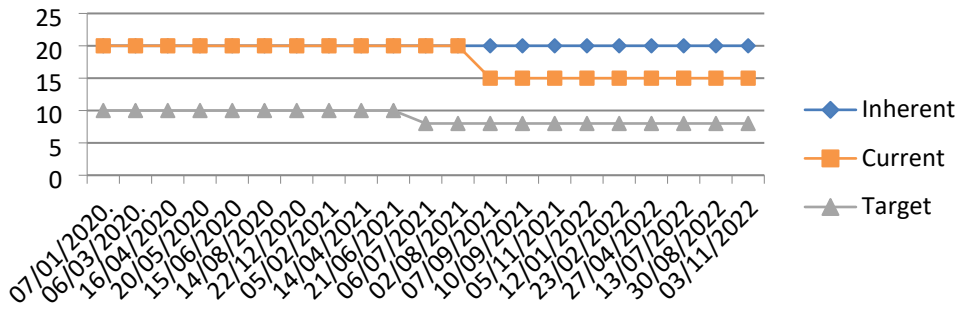
7.1 A full Equality Impact Assessment has been completed in relation to the new Risk Management Strategy to which CRR reports are aligned.

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

Appendix 1 – Corporate Risk Register

CRR20-01	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 03 November 2022
	Risk: Asbestos Management and Control	**Date of Committee Review:** 01 November 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.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

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. 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 and in place. Review of systems and procedures in line with the Asbestos management policy.	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 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 82%. Targeted action through local operations managers will be focused upon to reach 95% and it is anticipated that this will be achieved by quarter four in 2022/23. Whilst it was anticipated that the target score would have been met by quarter 1, staff shortages due to COVID have been experienced which have influenced the ability to achieve the target.

Progress since last submission
1. Controls in place reviewed to reflect current position. 2. Gaps in controls reviewed to reflect current position. 3. Asbestos Management Policy has been updated and revised version going for sign off at Quality, Safety and Experience Committee on the 1st November 2022. 4. Action ID 23728 - Action closed, review completed by the Senior Estates Officer/Asbestos Management with recommendations included within the report and implemented.

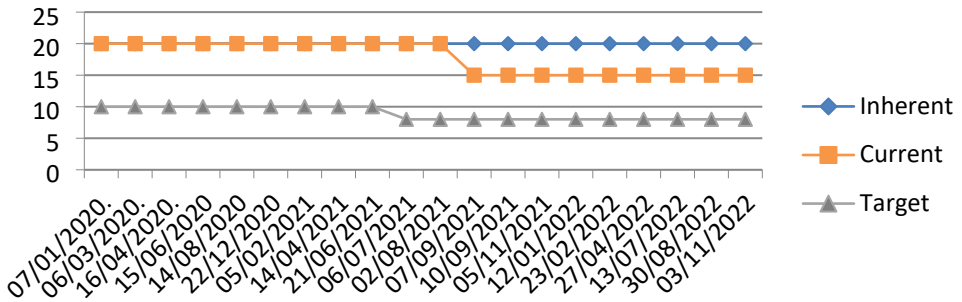
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

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. October 2022 progress update - Meeting held 31/10/2022 and agreed to purchase Asbestos module for MiCad, this will require investment in the MiCad management system.	On track

	23728	Implement recommendations following the review by the new Senior Estates Officer/Asbestos Management.	Hughes, Mr Arwel Hughes, Head of Operational Estates	31/03/2023	Action closed 03/11/2022 Provide assurance that the systems of controls are suitable and sufficient to meet the requirements of Asbestos Management Regulations. October 2022 progress update - Action closed, review completed by the Senior Estates Officer/Asbestos Management with recommendations included within the report and implemented.	Completed

CRR20-02	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 03 November 2022
	Risk: Contractor Management and Control	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023

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.	1. Health and Safety Leads Group. 2. Strategic Occupational Health and Safety Group. 3. Quality, Safety and Experience Committee.

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.	

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. Additional to current funding has been allocated from 23/24 for additional resources.

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. Action ID 12252 – Action delayed, operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems. 4. Action ID 12256 – Action delayed, the Health Board have signed off the frameworks access agreement for the purchase of the SHE software. 5. Action ID 12257 – Action delayed, Currently a paper exercise, which present a risk of failure to follow due process within the SOP. Once the SHE system is in place this will transform over to a digital relationship which will mitigate single point of failure. Senior Estates Officers/Estates Officers currently carry out the local inductions based on the Operational Estates Control of Contractors procedures guidance (SOP). 6. Action ID 12258 – Action delayed, operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems.

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 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. November 2022 progress update - Operating model agreed, this action will need to be aligned with each IHC's	Delay

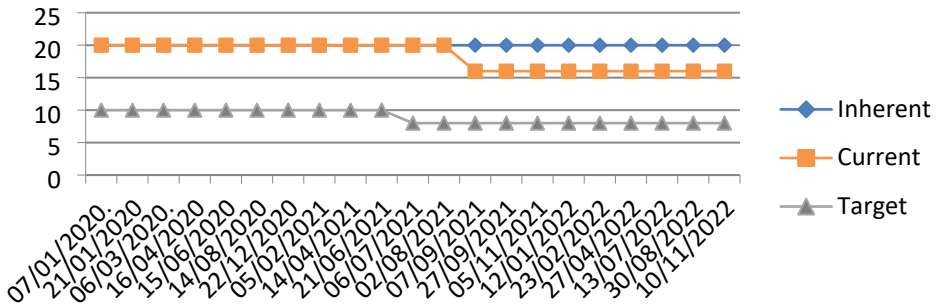
					Governance and Health and Safety Management systems.	
	12256	Identify the current system for signing in / out and/or monitoring of contractors whilst on site. Currently there is no robust system in place. Electronic system to be implemented such as SHE software.	Mr Rod Taylor, Director of Estates & Facilities	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. November 2022 progress update - The Health Board have signed off the frameworks access agreement for the purchase of the SHE	Delay
	12257	Identify level of Local Induction and who carry it out and to what standard.	Mr Rod Taylor, Director of Estates & Facilities	30/09/2022	Implementation of the 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	Delay

					ensure compliance with the Health Board Contractor Management Processes. November 2022 progress - Currently a paper exercise, which present a risk of failure to follow due process within the SOP. Once the SHE system is in place this will transform over to a digital relationship which will mitigate single point of failure. Senior Estates Officers/Estates Officers currently carry out the local inductions based on the Operational Estates Control of Contractors procedures guidance (SOP).	
	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.	Delay

					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. November 2022 progress update - Operating model agreed, this action will need to be aligned with each IHC's Governance and Health and Safety Management systems.	

CRR20-03	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 November 2022
	Risk: Legionella Management and Control.	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023

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 and Safety Committee. 2. Risk assessment undertaken by clear water, 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 clear water. 5. Water samples taken and evaluated for legionella and pseudomonas.	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.

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. 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. Estates & Facilities have undertaken a resources gap analysis to support improvement in compliance for water safety, this resource business case has been approved as part of the IMTP with funding agreed recurrently from April 2023, which will provide supported additional resource capacity to improve water safety compliance. This results in a lack of 3x band 7 senior estates officers for water safety. 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. Revised Water safety policy has been approved by the Water Safety Group and Infection Prevention Sub Group and will be submitted to the Quality, Safety and Experience Committee in November 2022. 4. As part of the appointment of the authorising engineer, targeted audits are planned for each of the 3 operational areas which commences in August 2022 with completion by end of March 2023 (outcomes from these audits will be considered for areas of improvement and mitigation should they be required). 5. As a result of concerns raised during the transition of data from the existing software model to a new model a targeted intervention with the appointed water safety contractor was required. This work is ongoing with additional resources allocated to the contract to address the issues identified, this has caused a delay, and will be recovered by 31/12/2022.

6. Standard Operating Procedure for management of little used outlets developed and approved by the water safety group and Infection Prevention Sub-Group. SOP to be presented to Strategic Occupational Health and Safety Group for approval to publish on Betsinet.
7. Action ID 12262 – Action closed as simplistic schematics of water systems are provided as part of the water safety risk assessments.
8. Action ID 12267 – Action delayed, awareness training is included within the Infection Prevention mandatory training module.
9. Action ID 19015 – Action delayed, the business case has been approved and looking at appointing to the roles.

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

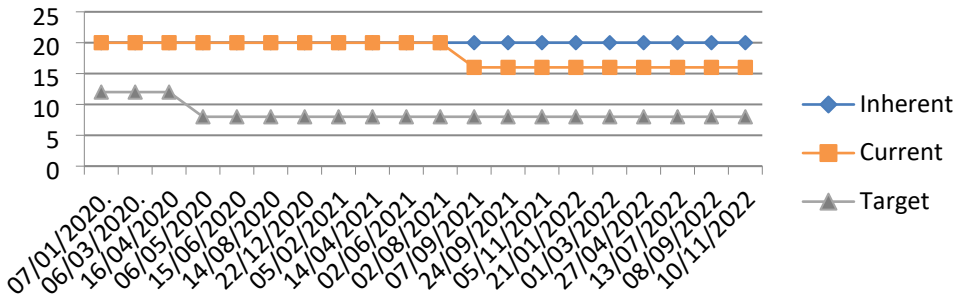
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	12262	Ensure that engineering schematics are in place for all departments and kept up 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	Action closed 10/11/2022 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	Completed

					has been approved by the Health Board in January 2021. November 2022 progress update - Action closed, simplistic schematics of water systems are provided as part of the water safety risk assessments.	
	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. November 2022 progress update - Awareness training is included within the Infection Prevention mandatory training module.	Delay
	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. November 2022 progress	Delay

					update - Business case has been approved and looking at appointing to the roles.	
	24081	Audit response following the Shared Services Authorised Engineer for Water Audit	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	Address any shortfalls identified as a result of the audit which will be required to be implemented. November 2022 progress update - Audit for the Central Region currently underway.	On track

CRR20-04	**Director Lead:** Executive Director of Finance	**Date Opened:** 07 January 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 10 November 2022
	Risk: Non-Compliance of Fire Safety Systems	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2025

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	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. Fire Safety Policy established and implemented, annual report reported 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.	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.

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. 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 Case (PBC) for additional funding to upgrade essential infrastructure measures to ensure compliance with current standards at Ysbyty Gwynedd and Wrexham Maelor hospitals. Ysbyty Gwynedd - Programme BC submitted to WG 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. Wrexham Maelor Hospital - £54m requested 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. Request for additional funding (£2.93m over a two year programme) through the All Wales EFAB (Estates Funding Advisory Board) route, this request is for upgrades to fire compartmentation and fire alarm systems for premises identified through fire safety risk assessments.

4. Corporate Health and Safety audit undertaken and a number of recommendations made which are being acted upon over the forthcoming months.
5. Action ID 12276 - Action delayed due to awaiting the All Wales guidance document for inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group. Meeting to be arranged with Corporate Health and Safety to ensure interim measures are in place.
6. Action ID 15036 - Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of March 2023.
7. Identification of new action ID 24397 to implement the recommendations following the Corporate Health and Safety audit.

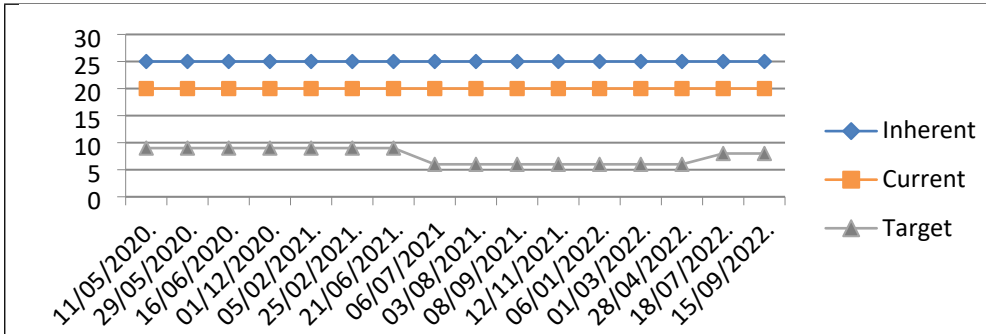
Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus Making effective and sustainable use of resources (key enabler)	BAF21-13 BAF21-17

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	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. November 2022 progress update - Action delayed due to awaiting the All Wales guidance document for inclusion in hospital evacuation plans from the all Wales Fire Safety Managers Group. Meeting to be arranged with Corporate Health and Safety to ensure interim measures are in place.	Delay
	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. November 2022 progress update - Action delayed due to insufficient capacity to ensure Fire Risk Assessments in place for all service areas across the Health Board, anticipated delivery by the end of March 2023.	Delay
	24142	Develop a Management structure to ensure adequate capacity to deliver Fire Safety	Mr Rod Taylor, Director of Estates & Facilities	31/03/2023	Ensure compliance with Fire Safety Legislation. Business case to be developed to	On track

		requirements within the Health Board.			secure funding to align with the new Fire Management structure.	
	24397	Implement recommendations following the Corporate Health and Safety audit	Mr Rod Taylor, Director of Estates & Facilities	31/12/2022	Ensure recommendations from the Corporate Health and Safety audit are implemented which will strengthen current policies and procedures.	On track

CRR20-05 – Proposed changes to be made to this Risk (see below)

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:** 15th September 2022
	Risk: Timely access to care homes	**Date of Committee Review:** 06 September 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.	1. Oversight via the Care Home Operational Group which includes representatives from Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW).

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). 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. This work is progressing well and risks are well managed and is now embedded into core work. 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.	2. Oversight by the Regional Commissioning Board who report to the Regional Partnership Board.

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. Work ongoing with IT and Performance to develop digital system which is currently being piloted. This will provide a more robust system of data collection, including delays by Local Authority. 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. The final draft PPA is currently with the LA commissioning teams, prior to being issued to independent providers in October. 5. Commissioned Placement Fee Setting - Health Board has agreed to make an interim uplift whilst awaiting national pay awards, but due to increasing economic pressures this is already being challenged as insufficient by providers. .

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. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the HB bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for HB, LA and the provider at each level of escalation

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). This is still in progress. 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 to 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 closed as it is not considered deliverable. Point 6 above provides mitigation.
10. Further consideration taken to develop a care provider risk, work is ongoing to develop this risk.
11. Significant progress has been made by the HB and partners in identifying 243 additional care placements (Gaps/ Controls). Capacity will be phased in from end of September. The schemes identified to achieve the additional capacity is being co-ordinated at Integrated Health Economy level, with the respective LAs, and will be subject to an assessment of deliverability (particularly focused on workforce availability). We will you now continue to work with social care, colleagues, colleagues in BCU and particularly work force, to ensure that there is no / minimal negative impact / destabilisation on other aspects of the Health and Social Care system. Reporting requirements and baselines are yet to be agreed.

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

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers.	Mrs Marianne Walmsley, Lead Nurse Primary and Community	30/04/2022	It will prevent admissions from Care Homes which have no staff and improve patient flow to enable discharge. September 2022 progress update - Action delayed. This was escalated to the Regional Workforce Board In July with the recommendation of appointing some dedicated support.	Delay

	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. Action closed as it is not considered deliverable. 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.	Completed
	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

CRR20-05 - Proposed Changes (CRR20-05 to be split into 2 separate risks) – 1.

	Director Lead: Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding**.**	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 November 2023
There is a risk that the current systems for commissioning placements with the independent sector has limited assurance in relation to delivering the right care, is improving outcomes and is providing value for money. This is caused by insufficient resource and expertise within the CHC and contracting teams and the Wales Audit recommendation to establish a Business Support Hub This may lead to people not receiving the correct package of care which may lead to harm, or that the Health Board is funding packages of care which people are not eligible for, it may also lead to delays in discharge/patient flow.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. Continuing Health Care Operations Group - 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. 2. Regional Commissioning Board (RCB) – joint chaired by Health & LAs and is responsible for delivery of the Wales Audit Management Plan for Commissioning Older Persons placements. 3. Fees Sub Group – reviewing current fees across health & Local Authorities. Fees methodology agreed for 2023 / 2024 (Sub-group of the RCB) in principle. Fees for this year do not have sufficient controls. 4. Senior Management Team – Care Providers. Membership and Terms of Reference under review to ensure fit for purpose 5. Contract Monitoring reporting for care home providers quarterly reported to PFIG and noted in the CHC Operational Group 6. Market Stability & Population Needs Assessment group with LAs to address commissioning strategies 7. BroadCare patient information system in place allowing for consistent monitoring of placements including numbers and finance 8. Establishment of the CHC Improvement Group – October 2022 (is also a gap as resources needed to deliver)	1. Regional Commissioning Board (Sub-Group of the Regional Partnership Board) has oversight which has representatives from the Health Board, Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Independent Care Provider SMT with representatives of the 3 IHCs, MH&LD and Finance and Contracts 3. Welsh Audit Management Action Plans

Gaps in Controls/mitigations
1. No signed Pre Placement Agreement (PPA) - current gap in contracted services with a risk of providers choosing not to sign a new PPA when it is approved for release: Individual CHC commissioners and wider teams continue to support an approach of as if inferred contract basis until the new PPA can be released early in 2023. Webinars are being arranged to provide information prior to release. 2. Financial overspend of £1.6m at month 5: Commissioned providers are experiencing high costs of care, which they continue to pass to commissioners on a case by case basis outside of regional fee agreements. Regional LA fees have been uplifted mid

year which has eroded the CHC enhancement we have always paid. Clarity on the HBs position and the potential financial impact to the HB will be covered in an Fees option to go to Executive team 23/11/2022
3. The regional fees group have agreed a single recommendation to section 151 LA officers for 2023 / 24, however the picture is complicated and this is unlikely to result in a single fee in reality, rather a single methodology where variations are described. This will be managed by representation from HB CHC and Contracts on the fees group.
4. Delivering the Older People's Care Home Placements Audit Wales recommendation two - reviewing arrangements for commissioning care home placements to eliminate avoidable adverse impacts on service users. Workshop has been held with the LAs (September 2022) and an action plan is being developed which will need sign off by RCB
5. Delivering the Older People's Care Home Placements Audit Wales recommendation four - to develop a regionally agreed care home commissioning strategy and associated delivery plan. Workshop has been held with the LAs (September 2022) and an action plan is being developed which will need sign off by the RCB.
6. CHC Audit Wales recommendation 3 – CHC Team Structure (reasonable assurance). How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
7. CHC Audit Wales recommendation 5 – CHC Contracting and establishment of the Business Support Hub (no assurance) – There is no formal structure or governance arrangements in place for the BSH. How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
8. No procurement, contractual and business support structures in the HB in addition to those to be supported by the proposed CHC Business hub for the required Direct Payments in CHC required by WG. – Linked to Recommendation 5 of Audit Wales.
9. CHC Audit Office Recommendation 2 –CHC Framework Training & Education, need to undertake Training Needs analysis for the organisation. CHC training attendance is challenging due to operational staffing issues. Currently exploring feedback of wider teams regarding recorded sessions with IT. How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
10. CHC Audit Wales recommendation 1 - Weaknesses in governance and oversight have led to inefficiencies, variation and tensions in the management of CHC. How this will be addressed will be set out in the Management Case Action plan for submission on 28th November 2022
11. BroadCare - Finance teams are working to develop more efficient back office functions with BC functions to remove unnecessary manual processes.
12. Informatics support – no dedicated support to support the contracting and quality agenda (ref. the Quality & Safety Corporate Risk)
13. CHC improvement Group established October 2022 – this work will not progress without dedicated support. Currently trying to release funding from this year's IMPT to support critical elements of this work.

Progress since last submission
This risk was formally part of CRR20-05 which is now being split into 2 separate risks, 'Insufficient grip and control on the contracting and commissioning of care packages for people eligible for Continuing Health Care Funding' and 'The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow.' 1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Identification of six new actions following the revision of the risk.

Links to	
Strategic Priorities	**Principal Risks**
Primary & Community Care Improved USC (Unscheduled Care) pathways	BAF21-03

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score		To develop a regionally agreed care home commissioning strategy and associated delivery plan. Clearly setting out the elements of the HBs commissioning strategy to include Commissioning of specialist placement on a regional basis (low	Kath Titchen, Commissioning Manager CHC	30/06/2023	1) Establish a Task and Finish group under the Regional commissioning Board to take this work forward	

		numbers / high cost) - (Gap / control No.4,5,13)				
		Agree mechanism for agreeing Fees – In year agree HBs position 2023/ 24 agree mechanism with LAs – (Gap / control No. 2 & 3)	Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/01/2023	1) Regional Fees Group in place – agree set of principles for all partners 2) In year up-lifts, further paper to Execs (end Nov 2022) setting out the current position and options for implementation including financial and flow risks	
		Full implementation of the Pre-Placement Agreement (Gap / control No. 1)	Kath Titchen, Commissioning Manager CHC	31/03/2023	3) Finalize PPA 4) Set up webinars for providers prior as part of the implementation 5) Establish a mechanism for electronic signature in line with IG 6) Agree with the LAs what the escalation process is for Homes which do not sign the PPA – will we commission placements?	
		To establish a Business Support Hub for the commissioning / procurement / brokerage (Gap / control No. 7,6,8,10,11,12)	Jane Trowman, Acting Assistant Director Care Homes Support &	30/06/2023	1) Draw down funding from IMPT to commence implementation including addressing CHC, Contracting, IT support 2) Via the CHC Improvement Group agree medium and longer term way forward	

			CHC Commissioning		3) Confirm arrangements for where this sits as part of the Operating Model (Commissioning / Contracts / Finance)	
		Move from spot purchasing to commissioning / placement / block purchasing with approved providers and be able to respond strategically e.g. with clear commissioning intentions to support the outcomes of the updated population needs assessment (Gap / control No. 4, 5, 7,8,10)	Kath Titchen, Commissioning Manager CHC	30/09/2023	1) Agreed process compliant with procurement requirements. Part of the Market stabilized Service specification 2) Lessons learnt from the Block Purchasing of Additional community Capacity 3) Establish a compliant process for Block purchasing in readiness for 23/24 winter pressures	
		CHC Framework – Training Needs analysis and development of key CHC role for admin and clinical staff competencies (Gap/control No. 9)	Sian Kelbrick, Head Of CHC Performance And Compliance	30/09/2023	1) Baselining the existing training programme, linking into nationally evolving CHC training requirements and support 2) Facilitate mitigation of imperfect patient journeys from the start of their care journey with CHC. 3) Through the existing regional LA HB CHC education strategic group will ensure that the key	

					themes across the region for CHC are addressed in the lessons learnt fed back into the training programs, hot spots identified and targeted support offered and associated wider system influencing issues escalated appropriately.	

CRR20-05 - Proposed Changes (CRR20-05 to be split into 2 separate risks) – 2.

	Director Lead: Executive Director Transformation, Strategic Planning, And Commissioning	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: The independent sector response to admission avoidance and timely discharge will not be robust enough to ensure optimal flow	**Date of Committee Review:** Revised Risk
		Target Risk Date: 31 January 2024

Due to the current fagility of the independent sector there is a risk that the quality and safey of patients who need to have their care delivered by independent providers could be compromised and there is potential for harm.

This could be caused by lack of timely prevention and early intervention from across Health & Social Care due to staffing (recruitment & retention), training education.

This may lead to unnecessary admission or conveyance to hospital, long lengths of unnecessary stay in hospital, untimely discharge from hospital (Patient Flow), insufficient staff within the care placement, and staff without the appropriate training and education. Organisational reputation due to high numbers of Medically Fit for Delays and inability to respond to other system pressures (Unscheduled & Planned Care)

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. North Wales care homes single action plan provides the framework and reports directly to the Regional Commissioning Board and Regional Partnership Board (RPB). 2. Quality Assurance Framework Implementation Group – underpinned by evidenced based Clinical Quality Tools 3. Programme of support to care providers (Training & Education) via the Care Provider Quality Assurance Framework. 4. Senior Management Team for Independent Providers – currently reviewing membership and terms of reference to ensure fit for purpose	1. Regional Commissioning Board (Sub-Group of the Regional Partnership Board) has oversight which has representatives from the Health Board, Care Forum Wales, Local Authority members and Care Inspectorate Wales (CIW). 2. Independent Care Provider SMT with representatives of the 3 IHCs, MH&LD and Finance and Contracts 3. CHC Improvement Group when fully established 4. Welsh Audit Management Action Plans

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 in progressed as part of the DU work on increasing community capacity to meet winter pressures (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 and to avoid hospital admission but insufficient domiciliary care provision to step down to. Health Teams providing domiciliary social care due to lack of LA commissioned services. HB currently becoming registered with CIW as a domiciliary care provider. 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. Work ongoing with IT and Performance to develop digital system which is currently

being piloted. This will provide a more robust system of data collection, including delays by Local Authority – this will link with national work on Pathways of Care Delays

4. 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. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the HB bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for HB, LA and the provider at each level of escalation to avoid further ombudsman reports of HB maladministration due to overdue reviews.

5. Overdue CHC placement annual reviews: Staffing issues, vacancies, recruitments and sick leave are affecting all areas: A breakeven at least business recovery proposal has been submitted through the IMTP, CHC Improvement group and HBLT.

6. CHC Audit Office Recommendation 3 – Consistent structure for CHC teams – not progressed as expected.

7. CHC Improvement Group Established – but insufficient resource to progress the work

8. Lack of Service Specification for care homes for nursing placements

9. Lack of Service specification for Domiciliary Complex care

10. Lack of Support to residential homes to prevent escalation in care needs in a timely way

11. Lack of Informatics support – no dedicated support to support the contracting and quality agenda (ref. the Quality & contracting risk)

12. Discharge Policy is out of date, WG currently revising Policy – including Reluctant Discharge Policy. Need to ensure consistent application of the policy and clear escalation pathways to support discharge

13. Impact on CHC teams to deliver services traditionally outside of CHC including LPS (Risk CRR21 -14) implementation, management and control of additional processes in reviews for circa 1500 complex patients annually. Implementation of interim arrangements and new emerging arrangements for Direct Payments, management of pathways outside of CHC/FNC/ and joint funded care for e.g. d2ra/ s2ra pathway.

14. Lack of and assurance framework with the independent sector to evidence that the care commissioned is being delivered and demonstrate how this is improving outcomes.

Progress since last submission
This risk was formally part of CRR20-06 which is now being split into 2 separate risks. 1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Identification of five new actions following the revision of the risk. 4. Action ID 22182 – Action transferred over from CRR20-05, action remains delayed due to the National review of the discharge policy. Draft is due to be issued November 2022, and full national launch in Jan 2023. 5. Action ID 18025 – Action transferred over from CRR20-05, action remains delayed with the Regional workforce board on the 14 November 2022. 6. Action ID 20074 – Action transferred over from CRR20-05, action closed. It has been agreed with partners that due to the current work force pressures across all sectors it is highly unlikely that the Health Board bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for Health Board, Local Authority and the provider at each level of escalation.

Links to	
Strategic Priorities	**Principal Risks**
Primary & Community Care Improved USC pathways	BAF21-03

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score		Programme of support to Residential Homes (Gap Control 1)	Marianne Walmsley, Head Of Quality For Care Homes	31/03/2023	1) Quality Assurance framework includes residential home developments 2) Clinical quality Support tools developed and being promoted to all local Authorities with some implementing across residential homes 3) All Corporate Care quality team training webinars made available to residential home staff 4) Funding sourced for residential care staff to attend local training courses in Llandrillo college 5) Monthly Provider brief to update on key issues, developments and training 6) Draft service specification for care providers	On track
		Additional resource to address Backlog of	Kath Titchen, Commissioning Manager CHC	31/01/2024	1) Options appraisal paper to HBLT to agree	On track

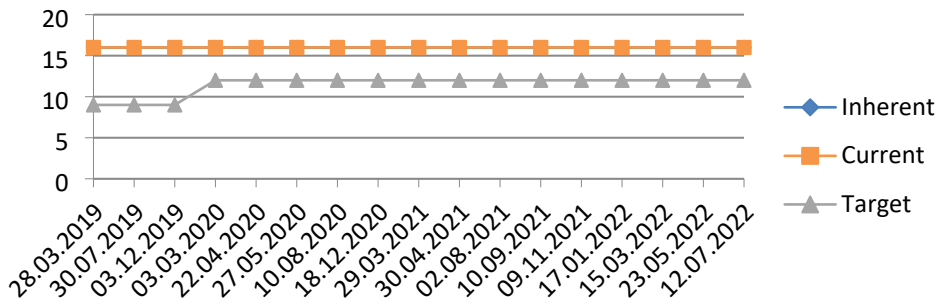
		reviews (Gap/control no.5)			preferred way of addressing the backlog 2) Establish Implement programme to address back log- prioritising on high risk quality categories 3) Identify quarterly trajectory	
		Airedale Programme to support Care homes including a focus on post discharge support (Gap/control No. 12)	Marianne Walmsley, Head Of Quality For Care Homes	31/12/2023	1) Funding identified from WG to pilot the project 2) Work commenced on identifying key homes with a high rate of WAST calls 3) Project group to oversee the pilot	On track
		Increasing Community Placements – Winter Pressures, including improving access to Domiciliary Care (Gap/control no. 1, 8)	Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/03/2023	1) Fortnightly meetings with DU and LAs 2) Delivery plan with monthly trajectories 3) Develop service specification for block purchasing beds in care homes to support flow 4) Develop pipeline schemes to further support winter pressures 5) Identify what works well and scale across North Wales	On track

	22182	Review and update Health Board Discharge policy. (Gap/control No. 12)	Ms Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/3/2022	This has been delayed due to the National review of the discharge policy. Draft is due to be issued November 2022, and full national launch in Jan 2023. Reminders to the operational teams have been issued to ensure they are working to the current policy including issuing of patient leaflets re: discharge and they have no right to remain in hospital when medically optimised for discharge Develop Standard Operating Procedure for the Health Board.	Delay
	18025	Working with the North Wales Regional Workforce Board to develop an improvement recruitment package for Independent Providers (Gap/control No. 4).	Mrs Marianne Walmsley, Head Of Quality For Care Homes	30/04/2022	Regional workforce board 14/11/2022.	Delay
	20074	Develop and Interim Bank for (Gap / Control No. 4)	Mrs Marianne Walmsley, Head Of Quality For Care Homes	31/01/2022	Action closed November 2022 It has been agreed with partners that due to the current work force pressures across all sectors it is highly	Completed

					unlikely that the Health Board bank would be able to provide staff. In order to identify further mitigation the 'Escalation Matrix' which was developed during covid has been reviewed. This is now more inclusive, with a focus on staffing, leadership, IPC, training, and Business Continuity, it sets out clear actions for Health Board, Local Authority and the provider at each level of escalation.	
		Implement the Audit Wales Management Action Plan for BCU – Currently limited assurance (Gap /Control No. 6)	Ms. Jane Trowman, Acting Assistant Director Care Homes Support & CHC Commissioning	31/07/2023	1) Management Action Plan to be submitted to Audit by 28th November 2022. 2) Implement Actions (TBC)	On track

CRR20-06 – Proposed changes to this risk (links into CRR22-32 and CRR23-33)

CRR20-06	**Director Lead:** Chief Digital and Information Officer	**Date Opened:** 28 March 2019
	Assuring Committee: Partnership, People and Population Health Committee	**Date Last Reviewed:** 12 July 2022
	Risk: Informatics - Patient Records pan BCUHB	**Date of Committee Review:** 12 July 2022
		Target Risk Date: 30 September 2024
There is a risk that patient information is not available when and where required. This may be caused by a lack of suitable storage space, uncertain retention periods, and the logistical challenges with sharing and maintaining standards associated with the paper record. This could result in substandard care, patient harm and an inability to meet our legislative duties.		



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
Current Risk Rating	4	4	16
Target Risk Score	4	3	12
Risk Appetite	Moderate level		9-12
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Informatics Strategy in place, with regular reporting to, Partnership, People and Population Health Committee. 2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB, monitored by the Patient Records Group. 3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance

4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. Centralised Team to manage 'Subject Access Requests' for Patient Records pan-BCUHB established, monitoring compliance with the legislation, monitoring compliance with legislation and supporting the rectification of commingling within patients clinical notes. 6. Standard Operating Procedure in place pan-BCUHB and off-site storage secured to manage the increased storage demands in response to the embargo on the destruction of patient records (in line with retention) due to the Infected Blood Inquiry. 7. Medical Examiners Service (MES) support teams established on each site to respond to the new requirements for providing scanned patient records to the MES in line with their standard operating procedures.	and Information Governance Committee. 3. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Delayed implementation and recruitment, to be able to digitalise all specialties within 4 years. Improved relationship with supplier and recruitment to take place with a phased approach for digital implementation. 2. Fit for purpose on site estate to hold physical records with the lack of current plans to scan records. The estate to hold physical records requires upkeep, current off site storage in place. 3. Lack of attendance at the Patient Records Group. Not all records custodians in attendance, monitoring and contacting leads within areas to implement change. 4. Lack of central oversight of records sent out by other departments. Urgent meeting to support standardisation and consistency of processes. Reporting of compliance to Patient Records Group to be implemented. 5. Compliance check for information sent out not robust. Band 4 staff currently quality checking information sent. 6. Local site improvement plans being developed in a silo manner without standardised approach across the Health Board. Health Records representation on improvement boards to be established.

Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. Action ID 12429 – Action remains on hold until the Mental Health Business Case is progressed with the Welsh Government. 4. Identification of new action ID 23746 to establish a new all encompassing Patient Records Programme that pulls all streams of work under one overall governance arrangement. 5. Identification of new action ID 23747 for the identification of recruitment for a Programme Manager to bring all strands of the patient records programme together. 6. Identification of new action ID 23748 for the Acting Executive Director of Therapies and Health Sciences to become the Senior Responsible Officer for the Clinical Records Standards element and The Chief Digital and Information Officer the Senior Responsible Officer for the Paper Records Management and CITO Electronic Document Record Management System elements. 7. Identification of new action ID 23749 to ensure that the DHR Programme is re-scoped into an Electronic Document Record Management System. 8. Identification of new action ID 23750 for the immediate review of the patient record policies, standard operating procedures and the associated delivery of training and awareness, to improve integrity and quality of information in clinical records as they are now in paper form.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

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	12423	Development of a local Digital Health Records system.	Aspinall, Mrs Nia, Head of Patient	30/09/2024	July 2022 progress update – An SBAR will be presented to the Executive Board during	On track

to achieve target risk score			Records and Digital Integration		August, requesting a re-scope of the project. However the early adopter work is still ongoing with both vascular and rheumatology. Full update and agreed recommendations to be provided after the Executive Board.	
	12425	Digitise the clinic letters for outpatients.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	31/12/2022	July 2022 progress update - Action remains delayed due to a delay in the start of the Medical Transcribing Electronic Discharge project, resources now in place.	On track
	12426	Digitise nursing documentation through engaging in the Welsh Nursing Care Record.	Brady, Mrs Jane, Senior Lead Nursing Informatics Specialist	30/09/2024	July 2022 progress update - Business case approved February 2022. Welsh Nursing Care Record now live across East community hospitals and all East medical and surgical wards in secondary care. This concludes the Welsh Nursing Care Record rollout in East. Planning for Central implementation has commenced with a proposed go live of mid-September 2022, starting in Ysbyty Glan Clwyd.	On track
	12429	Engage with the Estates Rationalisation	Aspinall, Mrs Nia, Head of	31/01/2023	ON HOLD until the Mental Health Business Case is	On Hold

		Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Patient Records and Digital Integration		progressed with the Welsh Government (5 case business cases) – break ground circa 2023, we will not be able to start the work to explore if the Ablett can be retained and redesigned for health records until the business cases are signed off. The date for the Mental Health Full Business Case is September 2022.	
	23746	A new all encompassing Patient Records Programme is established that pulls all streams of work under one overall governance arrangement.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	A programme in place that will support the mitigation of the risk with the central management and oversight of the individual elements.	On track
	23747	The identification or recruitment of a Programme Manager established for the overall programme and management to ensure all three elements are scoped and re-costed.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	The action will provide support in the mitigation of the risk with the central management and oversight of the individual elements.	On track
	23748	The Acting Executive Director of Therapies and Health Science become the Senior Responsible Officer for the Clinical Records Standards element and the Chief	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	These programmes require their scopes clearly being defined so that all are clear what they aspire to deliver and how to support the reduction in the risk score and reduce the volume of incidents, complaints	On track

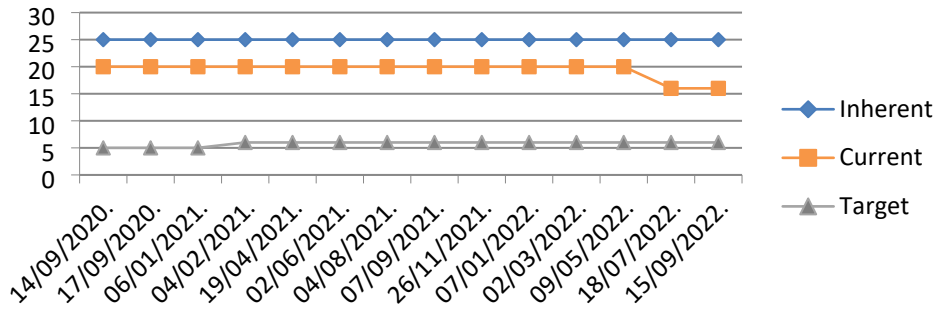
		Digital and Information Officer the Senior Responsible Officer for the Paper Records Management and CITO Electronic Document Record Management System (EDRMS) elements.			and claims regarding inappropriate record keeping.	
	23749	The Digital Health Record Programme is re-scoped into an Electronic Document Records Management System.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	To focus on addressing the more immediate patient records management challenges facing the Health Board utilising the proven capabilities of the CITO product.	On track
	23750	Immediate review of the patient record policies, standard operating procedures and the associated delivery of training and awareness and to improve integrity and quality of information in clinical records as they are now in paper form.	Aspinall, Mrs Nia, Head of Patient Records and Digital Integration	30/09/2024	Part of this work is currently underway as part of the Ysbyty Glan Clwyd improvement plan and when fully implemented will support the reduction in the risk score.	On track

CRR20-08 – Proposed changes to be made to this Risk (see below)

CRR20-08	**Director Lead:** Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 September 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 15 September 2022
	Risk: Insufficient clinical capacity to meet demand may result in permanent vision loss in some patients.	**Date of Committee Review:** 06 September 2022
		Target Risk Date: 30 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.	1. Risk is regularly reviewed at local

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 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. ODTC Single Tender Waiver enabled continuation of use of Primary Care Optometry (until September 2022). 8. Clinical condition dashboard now available for beta stage is live and implemented to support documentation and site self-management of clinical condition use to manage services. 9. Pan BCU Clinical Lead now appointed.	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. 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. The service will look to disaggregate the risk by the clinical conditions which will enable the risks to reflect impact on patient safety/care by the clinical conditions. Risk 1 - Delay of care leading to increased potential risk of Irreversible Sight-Loss (Predominantly Glaucoma/Diabetic Retinopathy/AMD). Risk 2 - Delay of care leading to increased potential risk of reversible Sight-Loss/risk of social isolation/falls/poor quality of life (Predominantly Cataract). The service are to meet with the Senior Management Team for Eye Care to discuss the risks and further develop. It is anticipated that the revised risks will be submitted to the next Risk Management Group meeting in December 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 the internal eye care business case, recruitment to support additional Intra Vitreal Therapy capacity is ongoing as well as the digital programme.	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. August 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 BCU post. Breakdown of current vacancies is being shared with pan BCU clinical lead who is exploring the potential of pan BCU posts with colleagues.	Delay

CRR20-08 – Proposed changes – AMD (Risk to be managed at Tier 1 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Age related Macular Degeneration: Intra Vitreal Injection Service (AMD)	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 June 2023
There is a risk that delayed access to timely AMD** care Pan BCU will lead to irreversible sight-loss for “New” and “Follow up” patients across North Wales. Inequities in timely access to care has been identified as a risk. Sustainability/core delivery challenges with staffing resource and training shortfall in all 3 sites. Leading to variance in access of timely treatment. Nov 2022 census: 257 patients overdue target wait (East 5/Central 229/West 23) Data Challenges (see separate Datix Data Quality Risk) have impacted on Data availability for performance modelling and Once for Wales’s equity assurance. Estates challenges in West (lack of “clean’’ room facilities) entail use of Theatre for IVT—entailing loss of Theatre capacity		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

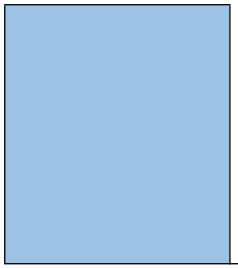
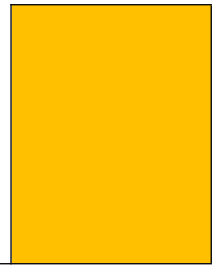
Controls in place	Assurances
1. Continuous monitoring of North wales AMD waiting list, to ensure equity through delivery of mutual aid and/or additional clinics (as required) 2. Dashboard to inform “live” (weekly refresh) waiting time position by site and pan BCU to inform continuous monitoring for equity assurance.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

Gaps in Controls/mitigations
1. Partial recruitment to funded posts, with East 0.5 WTE Consultant post and Central Nursing Band 3 0.3WTE outstanding. Clinical Lead/Sites exploring amalgamation of Consultant vacancies Pan-BCU with to achieve 1.0 WTE post with greater feasibility of recruitment.

Progress since last submission
This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. Transformation bid-secured staffing trained to enable competencies sign-off (Q2, 2022) 2. All non-Consultant Transformation funded posts recruited to, with exception of Band 3 HCSW (Central). West Locum mitigation/12 month Consultant recruitment recruited. Partial additional activity commenced April 22 (Full Achievement dependent on recruitment of Consultant 0.5wte vacancy and 0.3wte Band 3) 3. The identification of 2 open actions.

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	TBC	Continuous modelling of AMD waiting time BCU to inform additional Super-Saturday and Twilight Clinic requirements and Pan BCU Mutual Aid.	Operational Managers: Mandy Thomas, (East)/ Paula Betts, (Central)/ Alison Davies (West)	30/06/2021	Action Closed -Ensure equity of access across North Wales.	Completed
	TBC	Establish funding to train additional (1 per site minimum) non-medic to provide a more sustainable workforce (2022)	Jackie Forsythe, Network Manager/Eoin Guerin, Clinical Lead	30/06/2021	Action Closed -Increase service sustainability -Reduce waiting times	Completed
	TBC	Establish funding/recruit additional Nursing/Consultant/Administration Staffing to deliver 2 Lane IVT National Pathway	Jackie Forsythe, Network Manager/Eoin Guerin, Clinical Lead	30/06/2021	-Increase service sustainability -Reduce waiting times	Delay
	TBC	Longer-term: Explore potential of Regional Treatment Centre (RTC) potential to provide additional IVT Estates.	Jackie Forsythe, Network Manager/Roger Haslett, Clinical Lead	31/03/2023	-Provide estates to ensure 2-lane pathway, pathway delivery for patients Pan North Wales	On track

					-Redress of West IVT “Clean Room” capacity gap -Redress West Theatre capacity- loss to providing estate for IVT	

CRR20-08 – Proposed changes Cataract (Risk to be managed at Tier 2 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Cataract: Sustainability challenges and delay in equitable and timely access: causing reversible sight-loss	**Date of Committee Review:** Revised Risk
		Target Risk Date: 01 April 2024
There is a risk that (red Risk rated) Cataract patients will experience reversible sight loss. This is due to Pre-Covid demand-capacity gaps, increasing waiting times arising from a combination of:- delayed implementation of High Volume Low Complexity (HVLC) pathways, non-maximised theatre utilisation, staffing/skill-mix capacity gaps, estates that do not support effective pathway delivery, inequity of access across North Wales and Welsh 50% increase in waiting list backlog from Covid-19 mitigation. Red risk-rated Cataract Patients with delayed care are at risk of; social isolation, reduced quality of life, compromised employment and increased falls risk. In addition, organisational reputation from complaints erodes organisational reputation.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	3	4	12
	Current Risk Rating	3	4	12
	Target Risk Score	3	2	6
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in – Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. Increased Theatre utilisation plan for Complex patients. 2. Outsourcing mobilised and group in place to review progress against the contract. 3. 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. 4. 'Once for North Wales' process is in place, partially across all sites, Stage 1 Cataract patients may be shared across all three units in North Wales to ensure equity of access. (Do not have discrepancy wait exceeding 4 weeks across sites) 5. 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 clinic slots. No longer being utilised. All staff across 3 sites recruited except Consultant hours in East. Go live additionally being progressed.	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. 5. Performance reviewed at Secondary Care Accountability Meetings. (Performance Information Governance and Finance Group)

Gaps in Controls/mitigations
1. Mutual aid for patients with a discrepancy wait of >4 weeks in comparison to waiters on other sites has not commenced. Mitigating process is in development (Target Q4, 2022) 2. Complex theatre utilisation increase (BCU-based surgery) to ≥4 patients per theatre session (September 2022 target) delayed due to nursing capacity challenges. Matron review to identify solutions to commence November 2022 (Matron recruitment 1.11.22)

Progress since last submission
This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. Complex patient theatre utilisation roll-out Go Live commenced September 2022 on two sites (East and West). 2. Outsourcing capacity has increased from 400 to 600 monthly slots per month (including Stage 1 and Stage 4 provision) 3. Increased theatre utility (BCU-based surgery) to ≥4 patients per theatre session (East and West) from September 2022 4. Dashboard (patient level) disaggregated to cataract /weeks waited/risk level has significantly redressed “postcode” inequity of waiting times and assured care offered to longest-waiting patients with greatest risk and/or at risk of breaching Ministerial targets. 5. Identification of 3 open actions.

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	TBC	Develop Pan BCU Referral Refinement Pathway (Integrated with Primary and Secondary Care)	Operational Leads Mandy Thomas and Sarah Hughes (East)/ Alison Davies and Karen Evans (West)/Paula Betts and Andrew Collier (Central)	March 2019	Action closed March 2019 -Delivers risk stratification within 48 hours of referral. -Ensures patients with greatest risk provided with target date that reflects risk and quality of life impact to prioritise timely access to care for those with greatest risk of reversible sight loss	Completed
	TBC	Establish Dashboard (patient level) disaggregated to clinical condition/weeks waited/Risk level: with	Jackie Forsythe, Network Manager /Roger Haslett, Clinical Lead	June 2022	Action closed June 2022 -Assures patients with greatest need offered equitable, timely access to care (outsourced and within BCU)	Completed

		Pan BCU and by health community level			-Timely identification of cohort for HVLC and/or Outsourcing Pathway streaming: reducing prior clinician capacity-demand to deliver case-note review	
	TBC	Outsource 400 routine Stage 1 and/or Stage 4 (Local Anaesthesia Cataract patients/month): rising to 600/month September 22	Jackie Forsythe, Network Manager /Roger Haslett, Clinical Lead	31/03/2023	Redresses delayed care and waiting list backlog for Routine Cataract patients. On target for Stage 1 & 4 Ministerial target of zero >104 week breaches by close of March 2023	On track
	TBC	Increase theatre utility (BCU-based surgery) to ≥4 patients per theatre session from September 2022	Roger Haslett Clinical Lead	31/03/2023	Redresses delayed care and waiting list backlog for Complex Cataract patients. On target for Stage 1 & 4 Ministerial target of zero >104 week breaches by close of March 2023 Action on track for East and West Regions, anticipated delay for Central Region.	On track
	TBC	Deliver longer-term Cataract service sustainability through developing Regional	Jackie Forsythe, Network Manager /Roger Haslett, Clinical Lead	31/03/2027	Provides the estates and staffing resources to enable High Volume, Low Complexity Day	On track

		Treatment Centres in North Wales.			Case: essential for more sustainable Cataract services	

CRR20-08 – Proposed changes – Data Quality (Risk to be managed at Tier 2 level)

Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
Risk: Risk of Sight-Loss from Delayed Care as a consequence of Data Quality & Completeness gaps (All Patients)	**Date of Committee Review:** Revised Risk
	Target Risk Date: 31 March 2023
There is a risk that Data Quality challenges are negatively impacting upon assuring equitable and timely delivery of care to patients where delayed care can potentially lead to irreversible sight-loss. This is caused by a combination of: null data entry of "clinical condition" sub-speciality and/or codes used interchangeably for diverse clinical conditions across North Wales. West performance approaching "tolerance" until April 22 WPAS migration: requiring re-entry of Clinical Condition. Data quality is negatively impacting on demand & capacity modelling, planning, monitoring, equitable access assurance, transformation trajectory setting and identifying patients suitable for nurse-led and/or Integrated Pathways. (Nov 2022 Census: 6697 patients with "null" entry for clinical condition)	

		Impact	Likelihood	Score
To be populated following approval	Inherent Risk Rating	3	4	12
	Current Risk Rating	3	4	12
	Target Risk Score	3	2	6
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
1. Dashboard to enable sites to monitor (to patient level) null entries/ "live" performance. 2. Standard operating procedure (SOP)	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

3. Monthly performance reports to inform Operational Teams	

Gaps in Controls/mitigations
1. Administration capacity gaps from vacancies and unplanned leave, in addition to increased demand from increased Integrated Pathway activity, negatively impacted on redress of “historic nulls” and “coding variance”. 2.5 WTE additional (fixed term to 2023) admin resourcing funded from “Eye Care” to increase team capacity. Operational teams exploring administration capacity gaps, to identify longer-term solutions with Eye Care Network Manager. 2. Induction/training effectiveness “learning” and/or Operational Leadership capacity reduction contributed to reoccurrence of prior input-error trends. Operational teams refreshing “whole team” compliance with SOP. 3. Target for redressing “null” entries reset: Q2, 2021/ Q2, 2022/ Q3, 2022. Additional “pump-prime” administration resourcing released to close of March 2023. 4. Delayed care/delivery of Health Risk Factor Target date (appointment set by clinician that reflects risk-level/patient specific need): potentially leading to increased risk of Irreversible Sight-Loss.

Progress since last submission
This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. Sites established Standard Operating Procedures and refreshed staff June 2021 2. Power bi Clinical Condition & HRF Dashboard achieved (June 2022) * Further enhancement/coding breakdown July 2022. 3. Additional “fixed term” administration support funded to March 2023, to increase team capacity. 4. Identification of 2 open actions.

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	TBC	All sites to establish Standard Operating Procedures to guide WPAS inputters	Operational/Clinical Leads (Ophthalmology)	31/12/2021	-Assures standardised data (Clinical Condition and Sub-spec coding) to redress “root cause” and reduce “new null” additions.	Completed
	TBC	Clinical Condition and HRF Dashboard to be established	Clinical Lead/Operational Lead	31/03/2022	- Enables “live” weekly monitoring and patient-level “drill down” to support timely site self-management of Data Improvement and maintenance	Completed
	TBC	Sites to deliver action plans to redress backlog of historic” nulls”	Clinical Lead/Network Manager	31/12/2021 (reset target)	Identification of patients “by condition” enables streaming to appropriate pathways, including Integrated Pathways resourced by Primary Care: reducing patient waiting times and risk from delayed care	Delay
	TBC	Review Administration capacity/gap analysis	Operational Leads	31/03/2023	Ensure sustainable workforce to deliver and Data Quality and completeness	On track

CRR20-08 – Proposed changes – Diabetic Retinopathy (Risk to be managed at Tier 2 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Risk of Irreversible Sight-Loss from Delayed Care for "New" and "Follow-Up" Diabetic Retinopathy Patients	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 June 2024

There is a risk that equitable access to timely Diabetic Retinopathy** care will lead to irreversible sight-loss for patients across North Wales. This is caused by sustainability challenges arising from a combination of: delayed delivery of National Digital (E-referral and electronic patient record) essential for effective Integrated delivery, staffing capacity gaps, West estate resource challenges, non-medic skills shortfall for enhanced role achievement, Ophthalmologist capacity shortfall delaying "non-medic" competency sign-off and variance in clinician appetite to progress integrated (primary Optometrist & secondary care) pathways to release capacity and reduce waiting times.

**All Retinopathy patients are R1 (at risk of irreversible sight-loss from delayed care.) Currently patients on waiting list Pan BCU: with 1,533 breaching National KPI ≤25% over target wait. (Breakdown: East zero. Central 610, West 923.*)

*Caveat: Data Challenges impact on "live" quantification/assurance of waiting list "by condition" numbers (See Datix Data Quality Risk)

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	3	12
	Current Risk Rating	4	3	12
	Target Risk Score	4	2	8
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Efficient flow of Diabetic Retinopathy patients to Integrated pathways delivered by contracted Primary Optometry Diagnostic & Treatment Centres (P-ODTCs) B. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in Diabetic retinopathy monitoring 1. Nurse, Orthoptist and Optometrist skills developed through courses, placements and Ophthalmologist competency oversight: to deliver skilled workforce working to top of competence. This workforce to release Medic and/or senior nurse capacity. C. Once for Wales Secure record sharing (National Openeyes Digital System) 1. BCU plan for implementing National Digital System: to enable effective information sharing for Integrated pathways delivery. System is key determinant for expanding Integrated Pathways whilst mitigating capacity demand on hospital administration.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

Gaps in Controls/mitigations
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Central IHC paused flow of a combined total of 480 Diabetic/Glaucoma patients to Primary Care ODTCs from September 21, due to Administration vacancy/unplanned leave impacts. 2. Historic capacity gap in hospital placement provision and Ophthalmologist mentors for Higher qualification and competency “sign-off capacity” has negatively impacted on delivery of “enhanced-skill” Nursing and Optometrist workforce. 3. Primary Care OTDC capacity (West and East) reduced by circa 25%, due to unplanned leave. Partial mitigation achieved through “recovery” trajectory. National Contractual Reform to commence 2022/2023: which would expand Primary Care “workforce”. Workforce predicted Nationally to offer >30% follow up capacity for Diabetic Retinopathy Follow ups. In interim, current P-ODTC contract revisited to offer “wider” cohort of contractors delivering current trajectory, to provide improved contingencies and patient access (Q4, 2022)

B. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring

1. North Wales region is a national outlier in terms of Primary-care non-medic workforce: in terms of staffing numbers and Higher level qualifications.
2. There is a Nursing enhanced role shortfall, with Ophthalmologist capacity shortfall/vacancies delaying “non-medic” competency sign-off

Currently all sites offering Primary Care placements, within capacity. Capacity to support placement challenged by vacancies of senior clinician roles (Consultant 1.5WTE/Registrar 2.0WTE and Band 7 Nursing). BCU currently exploring with Welsh Government proposal to establish a Train & Treat Centre in North Wales. This would offer two years funding (Welsh Government) and additional treatment for a minimum of 1000 glaucoma, 800 AMD and 2000 acute patients per year. (On basis of full-capacity of 12 Independent Prescribing, 6 Higher glaucoma and 6 Medical Retina Higher Qualification placements)

D. Once for Wales Digital “Secure Folder/file Sharing

1. National programme delayed by circa 9 months, with consequence of significant increase on administration capacity, due to increased scanning/secure sharing of information with Primary Care contractors to mitigate delayed digital enabler. Interim digital solutions explored with Informatics. Diabetic Retinopathy Referral refinement pathway cannot commence until system implemented: delaying achievement of 30%-50% “false positive” Retinopathy referrals waste reduction (Specific to referrals from Diabetic Eye Screening Wales.)

E. Workforce Review to assure a sustainable, prudent workforce

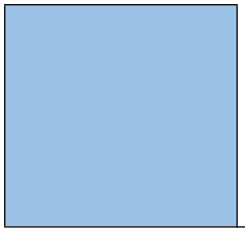
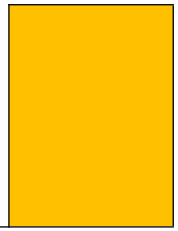
1. A full service review with supporting 5 year workforce plan was recommended in 2019, within 2019 Transformation Business case that concluded *“workforce is historical and not based on population demand”*. 2021 Wales Audit report called for development of a “*single medium-term workforce plan for eye care services (acute and NHS funded community services) that links to the future intended models of care”*: with BCU Audit recording Workforce as Leading delivery. This will be raised as a priority to develop within Ophthalmology and Planned Care strategic meetings in Q3, 2022. A determining factor to delivery is confirmation of Contractual Reform Pathways (circaQ1, 2023)

Progress since last submission
Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Central IHC paused flow of a combined total of 480 Diabetic/Glaucoma patients redressed. Flow recommenced September 22. Once for Wales Digital "Secure Folder/file Sharing 1. "Go Live Testing of internal systems Interim digital solution to mitigate Delayed National programme successfully tested/governance assured. Test of Change completed, with implementation on track for Q3 implementation for feasible pathways This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks. 1. The Identification of 5 open risks.

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	TBC	Deliver Interim Digital systems prior to National System "Go Live"	Dewi Edwards, BCU Regional Architect	31/12/2022	Partially reduce avoidable capacity loss, negatively impacting on administration teams and consistent delivery of Primary ODTC pathways (Currently unfeasible for "referral refinement" pathways)	On track

	TBC	Review and assure consistent flow of patients to P-OCTCs	Paula Betts, Lead Manager - Surgical (Central)	31/12/2022	-Assure maximum utilisation of contracted capacity -Reduce Diabetic Retinopathy patient waiting times -Redress (central) patient inequitable access to Care Closer to Home	On Track
	TBC	Explore delivery of Welsh Government funded Train and Treat Centre in North Wales	Richard Price, Optometry Advisor/Jackie Forsythe, Eye Care Network Manager/Roger Haslett, Clinical Lead	31/03/2023	- Redress historic capacity gap in hospital placement provision -Reduce competency-oversight demand on Senior Nurse/Ophthalmologist's -Increase "pool/cohort" of Non-medics with Higher qualifications/competencies to enable extension of "Integrated Workforce"	On track
	TBC	Development of a "single medium-term workforce plan for eye care services (acute and NHS funded community services)	Nikki Ffoulkes, Planned Care/Roger Haslett, Clinical Lead/Richard Price, Optometry Advisor	30/06/2023	- Identify skill mix and capacity requirement of workforce to provide sustainable delivery of intended models of care	On track
	TBC	Complete Non-Medic Training Needs Analysis	Richard Price, Optometry Advisor/ Mannon Jones Ophthalmology Sister (West)/	31/03/2023	-Enable delivery of an Integrated Training Plan: to best assure increased "pool/cohort" of Non-medics with Higher qualifications/competencies to	On track

			Sister Llinos Brown (East)/Hazel Foulkes, Ophthalmology Sister Central		enable extension of “Integrated Workforce”	

CRR20-08 – Proposed changes – Glaucoma (Risk to be managed at Tier 1 level)

	Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services	**Date Opened:** 14 November 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Risk of Irreversible Sight-Loss from Delayed Care for "New" and "Follow-Up" Glaucoma Patients	**Date of Committee Review:** Revised Risk
		Target Risk Date: 30 June 2024

There is a risk that delayed access to timely Glaucoma** care Pan BCU will lead to irreversible sight-loss for "New" and "Follow up" patients across North Wales. This is caused by sustainability challenges arising from a combination of: delayed delivery of National Digital (E-referral and electronic patient record) essential for effective Integrated delivery, staffing capacity gaps, West estate resource challenges, non-medic skills shortfall for enhanced role achievement, Ophthalmologist capacity shortfall delaying "non-medic" competency sign-off and variance in clinician appetite to progress integrated (primary Optometrist & secondary care) pathways to release capacity and reduce waiting times.

**All Glaucoma patients are R1 (at risk of irreversible sight-loss from delayed care.) Currently 8,381 Glaucoma patients on waiting list Pan BCU: with 5,562 breaching National KPI ≤25% over target wait. (Breakdown: East 2,303. Central 2,341, West 918.)

*Caveat: Data Challenges impact on "live" quantification of waiting list "by condition" numbers (See Datix Data Quality Risk)

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	4	3	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - Revised Risk not presented to Board	Revised Risk		

Controls in place	Assurances
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. Site assurance of efficient utilisation of peripheral Hospital clinics estates capacity; to release estate and staff resource capacity in secondary care, for reinvestment to achieve waiting time reduction. 2. Efficient flow of patients to Integrated pathways delivered by contracted Primary Optometry Diagnostic & Treatment Centres (P-ODTCs) B. Waiting List Reduction through SOS:- 1. Ocular Hypertensive and Glaucoma Stable SOS pathway (2016 directive from Welsh Government) reviewed and commenced progression Q2, 2022. C. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring: 1. Nurse, Orthoptist and Optometrist skills developed through courses, placements and Ophthalmologist competency oversight: to deliver skilled workforce working to top of competence. This workforce to release Medic and/or senior nurse capacity. D. Once for Wales Secure record sharing (National Openeyes Digital System) 1. BCU plan for implementing National Digital System: to enable effective information sharing for Integrated pathways delivery. System is key determinant for expanding Integrated Pathways whilst mitigating capacity demand on hospital administration.	1. Monthly report to Operational Leads 2. Monthly escalation report to Eye Care 3. Collaborative Group and Performance Finance Information Governance Group (PFIG)

Gaps in Controls/mitigations
A. Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :- 1. West IHC have been challenged in securing peripheral clinics estates to deliver nurse-led ODTCs in Alltwen Hospital. Nursing Matron actively exploring alternate options.

2. Covid social-distancing mitigations reduced Nurse-led ODTC clinic utilisation from Pre-Covid 8 patients/ per clinic to av. 5/clinic Pan BCU. IHCs progressing target to achieve Pre-Covid capacity and progression of 9 patients/clinic toward National target. Q3, 22
3. Central IHC paused flow of a total of 480 Glaucoma patients to Primary Care ODTCs from September 21, due to Administration vacancy/unplanned leave impacts. Flow recommenced September 22.
4. Historic capacity gap in hospital placement provision and Ophthalmologist mentors for Higher qualification and competency "sign-off capacity" has negatively impacted on delivery of "enhanced-skill" Nursing and Optometrist workforce.
5. Primary Care OTDC capacity (West and East) reduced by circa 25%, due to unplanned leave. Partial mitigation achieved through "recovery" trajectory. National Contractual Reform to commence 2022/2023: which would expand Primary Care "workforce". Workforce predicted Nationally to offer >30% follow up capacity for Glaucoma Follow ups. In interim, current P-ODTC contract revisited to offer "wider" cohort of contractors delivering current trajectory, to provide improved contingencies and patient access (Q4, 2022)

B. Waiting List Reduction through SOS:-
1. Variation in Clinician appetite/"Buy In" for Integrated Pathway partnership with Primary Care. Shared understanding supported by engagement sessions held in 2019, 2021 and 2022. Continuous improvement Networks additionally review current practice against National Pathways: with outcome of East and West "On Track" for SOS and Intraocular Pressure Pathway trajectory delivery in Q3, 2002. SOS Lead, liaising with Central clinical colleagues Nov 22

C. Skill-Enhancement of Non-Medics: to develop an integrated workforce, trained and competent in glaucoma monitoring
1. North Wales region is a national outlier in terms of Primary-care non-medic workforce: in terms of staffing numbers and Higher level qualifications.
2. There is a Nursing enhanced role shortfall, with Ophthalmologist capacity shortfall/vacancies delaying "non-medic" competency sign-off.
Currently all sites offering Primary Care placements, within capacity. Capacity to support placement challenged by vacancies of senior clinician roles (Consultant 1.5WTE/Registrar 2.0WTE and Band 7 Nursing). BCU currently exploring with Welsh Government proposal to establish a Train & Treat Centre in North Wales. This would offer two years funding (Welsh Government) and additional treatment for a minimum of 1000 glaucoma, 800 AMD and 2000 acute patients per year. (On basis of full-capacity of 12 Independent Prescribing, 6 Higher glaucoma and 6 Medical Retina Higher Qualification placements)

D. Once for Wales Digital "Secure Folder/file Sharing

1. National programme delayed by circa 9 months, with consequence of significant increase on administration capacity, due to increased scanning/secure sharing of information with Primary Care contractors to mitigate delayed digital enabler. Interim digital solutions explored with Informatics. Glaucoma Referral refinement pathway cannot commence until system implemented: delaying achievement of 30% “false positive” Glaucoma referral waste reduction

E. Workforce Review to assure a sustainable, prudent workforce

1. A full service review with supporting 5 year workforce plan was recommended in 2019, within 2019 Transformation Business case that concluded *“workforce is historical and not based on population demand”*. 2021 Wales Audit report called for development of a “*single medium-term workforce plan for eye care services (acute and NHS funded community services) that links to the future intended models of care”*: with BCU Audit recording Workforce as Leading delivery. This will be raised as a priority to develop within Ophthalmology and Planned Care strategic meetings in Q3, 2022. A determining factor to delivery is confirmation of Contractual Reform Pathways (circaQ1, 2023)

Progress since last submission

Maximising Non-medic led Pathways to release Secondary Care clinician & estate capacity and reduce waiting times :-

1. IOP Integrated pathway revisited by Clinical Networks and ratified Pan BCU July 22. East and West IHCs commenced roll-out October 22. Central agreement to partially commence confirmed Q3, 2022.

Waiting List Reduction through SOS:-

1. SOS Discharge pathway (Ocularhypertensive and Glaucoma stable) revisited: with East and West Integrated Health Communities commencing roll-out November 22.

Skill-Enhancement of Non-Medics:

1. Transformation bid formulated and funding to close of March 23 agreed with Welsh Government (WG). This is enabling backfill to release three Band 6 Nurses for placement/skill-enhancement to enable additional non-medic activity for high-risk patients in 2023 (with provisional WG funding agreement for Twilight funding upon completion of training (23-2024)

Once for Wales Digital “Secure Folder/file Sharing

1. “Go Live Testing of internal systems Interim digital solution to mitigate Delayed National programme successfully tested/governance assured. Test of Change completed, with implementation on track for Q3 implementation for feasible pathways.

This risk was formally part of CRR20-08 which is now being disaggregated into individual clinical condition risks.

1. The identification of 7 open actions.

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	TBC	Explore peripheral estate options for Nurse-led ODTCs	Sandra Robinson-Clark, Ophthalmology Nursing Matron (West)	31/12/2022	-Releases estate capacity within Ysbyty Gwynedd Eye Clinic	On Track
	TBC	Deliver increased nurse-led ODTC clinic utilisation “Test of Change”	Mannon Jones Ophthalmology Sister (West)/ Sister Llinos Brown (East)/Hazel Foulkes,	31/03/2023	-Reduces Glaucoma patient waiting time	On track

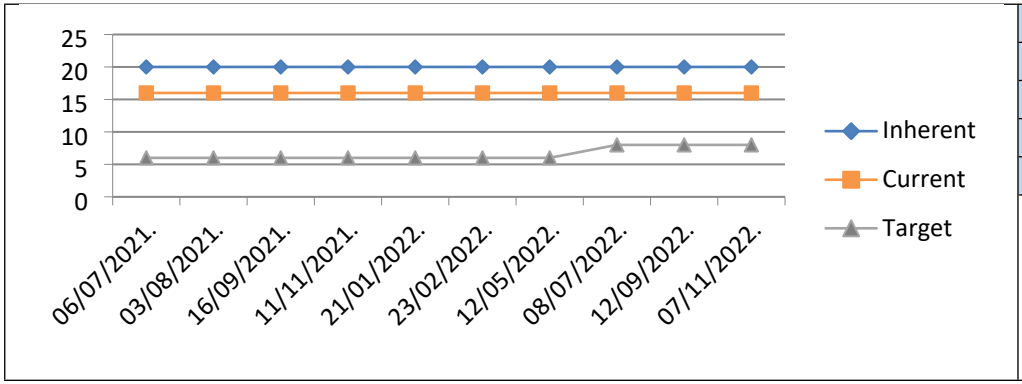
			Ophthalmology Sister Central			
	TBC	Deliver Interim Digital systems prior to National System “Go Live”	Dewi Edwards, BCU Regional Architect	31/12/2022	Partially reduce avoidable capacity loss*** negatively impacting on administration teams and consistent delivery of Primary ODTC pathways (***Currently unfeasible for “referral refinement” pathways)	On track
	TBC	Review and assure consistent flow of patients to P-OCTCs	Paula Betts, Lead Manager - Surgical (Central)	31/12/2022	-Assure maximum utilisation of contracted capacity -Reduce Glaucoma patient waiting times -Redress (central) patient inequitable access to Care Closer to Home	On Track
	TBC	Explore delivery of Welsh Government funded Train and Treat Centre in North Wales	Richard Price, Optometry Advisor/Jackie Forsythe, Eye Care Network Manager/Roger Haslett, Clinical Lead	31/03/2023	- Redress historic capacity gap in hospital placement provision -Reduce competency-oversight demand on Senior Nurse/Ophthalmologist’s -Increase “pool/cohort” of Non-medics with Higher qualifications/competencies to enable extension of “Integrated Workforce”	On track
	TBC	Development of a “single medium-term workforce plan for eye care services (acute	Nikki Ffoulkes, Planned Care/Roger Haslett, Clinical Lead/Richard	30/06/2023	- Identify skill mix and capacity requirement of workforce to provide sustainable delivery of intended models of care	On track

		and NHS funded community services)	Price, Optometry Advisor			
	TBC	Complete Non-Medic Training Needs Analysis	Richard Price, Optometry Advisor/ Mannon Jones Ophthalmology Sister (West)/ Sister Llinos Brown (East)/Hazel Foulkes, Ophthalmology Sister Central	31/03/2023	-Enable delivery of an Integrated Training Plan: to best assure increased “pool/cohort” of Non-medics with Higher qualifications/competencies to enable extension of “Integrated Workforce”	On track

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:** 07 November 2022
	Risk: Nurse staffing (Continuity of service may be compromised due to a diminishing nurse workforce)	**Date of Committee Review:** 01 November 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 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.	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 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 support4. 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.

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.	

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 reviewed to ensure relevance with current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. The Autumn nurse staffing reviews are complete with the statutory nurse staffing levels report due at board early November 2022. 4. The overseas nurse recruitment business case is in the final stages of approval, having been noted at Executive Delivery Group, with minor amendments required prior to final approval. 5. Action ID 15635 – Action closed, the original business case has been superseded and incorporated into the new People Operating Model, action closed and will be implemented as part of the role out of the new People Operating Model. 6. Action ID 17433 – Action delayed, Proposal to extend the action due date from the 31/03/2022 to the 31/03/2023 as this piece of work will fall under the 'Our way of Working' workstream. The first pilot cohort of a Matrons Leadership Programme concluded in September 2022. The programme has been recently evaluated and a report on the outcomes is to be presented to Nurse Directors Group in December 2022. A leadership summit event to review leadership provision and develop a collective view on core principles is planned to take place at the end of November 2022. 7. Action ID 17509 – Action delayed, Director of Nursing Workforce to contact Welsh Government lead to ascertain the current position. Anticipated delay to the action due date. 8. Action ID 18834 – Action delayed, dashboard now developed, initial implementation will commence during November 2022, and a full implementation timetable will be in place by end of December 2022. 9. Action ID 22121 – Action delayed, Nurse staffing programme lead has been appointed, however, instability remains within senior nursing posts across the Integrated Health Communities. With the recruitment of key posts ongoing this action is delayed, anticipated until the end of November 2022. 10. 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. 11. Action ID 23095 - Action closed, business case submitted and being prioritised as part of the Integrated Medium Term Plan for 23/24. Initial gap analysis completed and initial team in place on a non-recurrent basis. 12. Action ID 24185 - Plans in place to Corporately recruit Health Care support Workers in readiness for the winter surge. A Corporate led recruitment event has taken place in November 2022 with a second planned for early December 2022. During the November event approximately 38 whole time equivalent Health Care Support workers were recruited to the Health Board.

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

Risk Response Plan	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
Actions being implemented to achieve target risk score	15635	Development of a recruitment and resourcing business case to go to Executives.	Mr Nick Graham, Workforce Optimisation Advisor	30/11/2021	Action closed 07/11/2022 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. November 2022 progress update - The original business case has been superseded	Completed

					and incorporated into the new People Operating Model, Action closed and will be implemented as part of the role out of the new People Operating Model.	
	17433	Introduction of leadership development programmes commencing with Matrons which will extend to include Ward Managers, Heads of Nursing and subsequently aspirant programmes.	Mrs Joy Lloyd, Senior OD Manager	31/03/2022	This action will support retention with providing developing opportunities but also aid delivery of the Quality & Safety strategy within the Nursing workforce. 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	Delay

					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. November 2022 progress update - the first pilot cohort of a Matrons Leadership Programme concluded in September 2022. The programme has been recently evaluated and a report on the outcomes is to be presented to Nurse Directors Group in December 2022. A leadership summit event to review leadership provision and develop a collective view	

					on core principles is planned to take place at the end of November 2022. Proposal to extend the action due date from the 31/03/2022 to the 31/03/2023 as this piece of work will fall under the 'Our way of Working' workstream	
	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 This action will embed global skills, learning and innovation into the organisation and further strengthen workforce development November 2022 progress update - Director of Nursing Workforce to contact Welsh Government lead to ascertain the current position. Anticipated delay to the action due date.	Delay
	18834	Introduce targeted monitoring across rosters, through Key Performance	Mr Nick Graham, Workforce	30/06/2022	Effective utilisation of substantive staff.	Delay

		Indicators management to reduce agency expenditure and maximise substantive staff usage.	Optimisation Advisor		November 2022 progress update - Dashboard now developed, initial implementation will commence during November 2022, and a full implementation timetable will be in place by end of December 2022.	
	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.	Mr Ade Evans, Vocational Education Manager	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. November 2022 progress update - Action remains on track for December 2022.	On track
	20039	Develop and implement a programme of work to ensure the impact of the safe staffing act is embedded in the Health Board's business planning cycle.	Mandy Jones, Deputy Executive Director of Nursing	30/12/2022	By embedding into the business planning cycle this will support a more integrated approach to ensure the safe staffing act is met through pathway re-design and nurse re-deployment across the Health Board. November 2022 progress update - Recognised in the Intermediate Medium Term Plan (IMTP) and work is	On track

					ongoing to implement the programme.	
	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. November 2022 progress update - Nurse staffing programme lead has been appointed, however, instability remains within senior nursing posts across the Integrated Health Communities. With the recruitment of key posts ongoing this action is delayed, anticipated until the end of November 2022.	Delay
	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 challenges. November 2022 progress update - Dependant on the people strategy being	Delay

					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	Action closed 07/11/2022 The infrastructure will enable the delivery of nursing workforce staffing and professional standards agenda/portfolio. November 2022 progress update - Action closed. Business case submitted and being prioritised as part of the Integrated Medium Term Plan for 23/24. Initial gap analysis completed and initial team in place on a non-recurrent basis.	Completed
	24185	Corporate recruitment of Health Care Support workers to close the vacancy gaps and provide a stable and resilient workforce ahead of anticipated winter pressures.	Mrs Alison Griffiths, Director of Nursing Workforce	31/12/2022	Provide a stable and resilient workforce ahead of anticipated winter pressures, and associated increased activity and patient acuity. 3 phased approach will be taken phase 1 will recruit from the existing bank of staff,	On track

					phase 2 will recruit from an identified number of individuals that have recently applied for a post within the Health Board, and phase 3 will involve a well-publicised recruitment campaign targeted at the public, this is provisionally booked for mid November 2022 with checks and offers being made on the day. N 2022 progress update - Plans in place to Corporately recruit Health Care support Workers in readiness for the winter surge. A Corporate led recruitment event has taken place in November 2022 with a second planned for early December 2022. During the November event approximately 38 whole time equivalent Health Care Support workers were recruited to the Health Board.	
	24359	Monitor prioritisation of the Nurse Workforce and staffing resource requirements as part of the IMTP planning process to ensure	Mrs Alison Griffiths, Director of Nursing Workforce	31/03/2023	Provide sufficient resource to support nurse recruitment and retention in areas such as overseas nurse recruitment and student nurses.	On track

		sufficient resources are made available to support nurse recruitment on a recurrent basis.				

CRR21-14	**Director Lead:** Executive Director of Nursing and Midwifery.	**Date Opened:** 20 August 2021
	Assuring Committee: Mental Health and Capacity Compliance Committee	**Date Last Reviewed:** 24 October 2022
	Risk: There is a risk that the increased level of DoLS activity may result in the unlawful detention of patients.	**Date of Committee Review:** 04 November 2022
		Target Risk Date: 31 October 2023

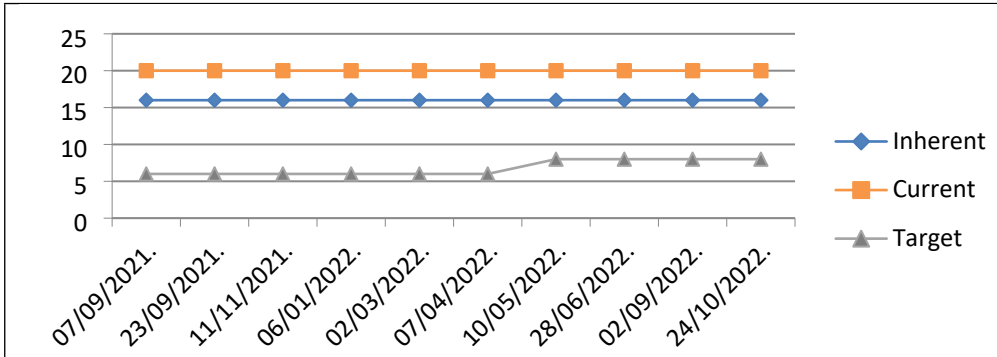
There is a risk that the increased level of Deprivation of Liberty Safeguards (DoLS) activity may result in the unlawful detention of patients.

This may be caused by the increased number of patients who are refusing admission or who have a mind altering diagnosis which reduces their capacity and cannot consent to their continued admission in an NHS hospital setting (meets the legal framework).

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

The amendments to the Mental Capacity Act, resulting in new legislation and the required preparation by the Welsh Government for the implementation of the Liberty Protection Safeguads (LPS) requires engagement at a National, Regional and Local level which has resulted in the divertion of resources.

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



	Impact	Likelihood	Score
Inherent Risk Rating	4	4	16
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. Standardised formal reporting and escalation of activity, mandatory compliance and exception reports are presented to the Mental Health and Capacity Compliance Committee (MHCCC), Patient Safety Quality Group and Safeguarding Forums in line with the Safeguarding Governance and Reporting Framework. 2. Audit findings and data are monitored and escalated following the Safeguarding Governance Reporting Framework. 3. BCUHB mandatory Adult at Risk training Levels 2 and 3 are in place for Mental Health and Learning Disabilities (MHLD) and key departments. This increases compliance with process and legislation and supports the reduction of unlawful detention. 4. The revised Deprivation of Liberty Safeguards (DoLS) Procedure is in place and provides a clear process and guidance to reduce legal challenge [21a]. 5. Deprivation of Liberty Safeguards (DoLS) COVID 19 Interim Guidance and Flow Chart is in place. This supports interim arrangements during reduced face to face contact. 6. Welsh Government interim monies has supported temporary resource to implement additional and bespoke Mental Capacity Act training in primary and community settings. 7. Welsh Government non recurring monies has been utilised to increase physical capacity in and out of hours to support the process of identifying patients on wards that could potentially be unlawfully detained to prevent harm to patients.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Board Workshop. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board to scrutinise safeguarding mortality reviews.

8. Liberty Protection Safeguards (LPS) Implementation group is in place to inform the organisation of LPS and to commence the preparation for the receipt of COP and future implementation of LPS across the organisation reporting to the Mental Health Capacity and Compliance Committee [MHCCC] Committee. 9. Welsh Government non recurring monies are identified to strengthen training and implementation of LPS for 16/17 year olds. 10. Heads of Safeguarding Strategic Objectives are cross referenced and include actions from the identified Safeguarding Risks ensuring triangulation and governance. These risks are monitored following the Safeguarding Governance Framework. 11. Welsh Government non recurring monies have supported the development of training materials for MCA, and the appreciation and understanding of capacity, which has included the reiteration of the safeguarding Team and the contact details.	6. Mental Capacity Act training compliance and DoLS backlog is monitored by the safeguarding governance and performance group reported into Welsh Government. 7. A Tracker is evidencing a reduction in delay, unlawful detention and backlog, monitored by the safeguarding team, which is reported to the MHCCC (Mental Health Capacity Compliance Committee). 8. The MCA awareness materials were disseminated from 14th November – Safeguarding Week.

Gaps in Controls/mitigations
1. New legislation and statutory guidance driven by case law immediately impacts upon the organisation and the date of implementation is not within BCUHB control. Training and guidance for 16/17 year olds has been developed until the statutory guidance is published. 2. New legislation and statutory guidance driven by the UK Government relating to the Liberty Protection Safeguards (LPS) is not within BCUHB control. Preparation and the implementation is dependent upon capacity, resource and expertise with the awaited revised Code of Practice. A BCUHB Business Case has been approved as part of the Integrated Medium Term Plan (IMTP) 2022-25 and will require implementation before the effects of this can support a reduction in the current risk score. The business case has been delayed presentation to the Board Workshop due to challenges (The next available date is Feb 2023). To support additional activity WG non recurring monies has supported the implementation of additional roles and activities. 3. The increase in safeguarding activity, with enhanced complexity has resulted in the delay of the implementation of strategic objectives and some operational proactive interventions. The increase in data reporting and supporting activity has supported the identification of risk and intervention. 4. Local Authorities frequently develop independent local guidance which requires duplication of implementation across BCUHB. This is time consuming, inhibits organisational standardisation, results in a variety of implementation activity and can result in reduced compliance. Some multi-agency guidance and intervention has been developed as a result of new Legislation and

national guidance, which is being overseen by the North Wales Safeguarding Boards and supports collaboration with partner agencies.
5. There is a lack of consistent training compliance rates across the Health Board. Deprivation of Liberty and Mental Capacity Act training is available on IT platforms. Alerts and reminders are provided by the Deprivation of Liberty Safeguards Co-ordinator to wards noting the timescales and legal duties. In addition, the number of 'Authorisers' across the organisation has increased with the additional provision of specialist training.
6. New Liberty Protection Safeguards Code of Practice is proposing that the commissioning arrangements of Independent Mental Capacity Advocates will be the responsibility of Health Boards on behalf of both health and local authorities. At present there is a lack of commissioned service in place and new arrangements require establishments in terms of governance arrangements and quality monitoring. Confirmed with WG and meeting arranged with the 6 local authorities.
7. Sudden rise in the number of DoLS assessment resulting in a backlog. We are, currently using non recurring Welsh Government monies to support current post holders to work additional hours, weekends and evenings (we are unable to recruit to specialist posts).
8. There is a lack of governance and reporting of Court of Protection activity relating to a Community setting, this was identified in a Court of Protection DoLS case and it is noted that this is not unique to BCUHB. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance. Immediate safeguards are in place and work is taking place alongside the Risk Team who has developed a SoP.
9. There are local and national staffing challenges with regard to the recruitment of MCA and DoLS (BIA) specialist staff. This has been recognised by Welsh Government. There are currently no Best Interest Assessor courses available to train staff as a result of the delayed authorisation of the Legal Framework. We are supporting flexible working arrangements, the immediate recruitment to vacancies and current post holders (BIAs) are working enhanced hours to deliver out of hours support. From November/December a 7 day MCA and DoLS advisory service using WG non recurring monies will be in place.
10. During Q2 2022-23 there has been an increase in the number of DoLS applications submitted by the Managing Authority 74% of all applications required amendments to the application prior to authorisation. A rolling audit activity with immediate escalation is in place.
11. The team and service is experiencing a combined sickness and vacancy position of 30%. A risk assessment and an amendment to the service delivery structure is in place to mobilise staff where required.
12. The development and ratification of strategic activities are delayed and some are outside of the original timescales. Risk assessments against each activity are in place to identify the risk and priority of the activity. Specific activities are highlighted to reporting Committees/Groups to obtain agreement if timescales require amendment or escalation.

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. Welsh Government monies identified to strengthen training and implementation of LPS for 16/17 year olds. 4. BCUHB have set up a Court of Protection DoLS Task and Finish Group with internal engagement to establish clear lines of accountabilities, escalation and governance in relation to identified community settings. 5. Action ID's 18117 and 21213 – Actions remain delayed. The Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The Workforce advice is to be obtained prior to submission to the Board Workshop. 6. Action ID 20957 – Action delay due to UK and Welsh Government for release of the code of practice. Notification received from Welsh Government which has referenced dissemination of the Code of Practice as Winter 2023. 7. Action ID 23066 – Action closed as evidence in place which identifies a reduction in the DoLS backlog by utilising Welsh Government monies. This activity remains under close monitoring arrangement and reports to Welsh Government on a quarterly basis. A new action (ID 24305) for the monitoring of Mental Capacity Act [MCA] training has resulted from the closure of this action as BCUHB continue to evidence low compliance with MCA mandatory training data. 8. Action ID 23505 – BCUHB hold geographical responsibility for the provision of IMCA services, following receipt of WG monies the safeguarding team are working with the six Local Authorities and IMCA providers to increase service provision in line with WG guidelines and national legislation. 9. Identification of new action - Using WG non recurring monies, current safeguarding team members are undertaking additional 'out of hours' (7 day service) DoLS assessments in-line with WG guidance and approval. This is monitored weekly to prevent staff 'burn out' and to support their health and wellbeing. This is funded via non recurring WG monies. 10. Identification of new action - Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients within the community. National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with Commissioning Services to support the development of a Standard Operating Procedure is underway. Training Data is under review relating to key services, with the objective to develop a bespoke training provision and evidence improved identification of service users who require a legal deprivation to be in place. 11. Identification of new action - Embed regular audits to monitor and implement actions to improve the current quality of DoLS applications. This will ensure that the documentation meets the requirements of the legal framework and BCUHB's legal duties in line with the Deprivation of Liberty Safeguards legislation.

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	18117	Recruitment to new posts required due to implementation of Liberty Protection Safeguards.	Michelle Denwood, Director of Safeguarding and Public Protection	01/04/2022	BCUHB IMTP resource will ensure the legal requirements of Liberty Protection Safeguards will be implemented and will reduce the number of unlawful detentions. The delay in the draft LPS Code of Practice has resulted in challenges to identify posts and evidence the required resource specific to LPS for the BCUHB safeguarding Business Case. Progress update WG has released non recurring monies (based upon a business case model) to support the preparation for LPS. This is to focus upon the	Delay

					implementation and awareness of the MCA and reduce the DoLS backlog. The Corporate Safeguarding IMTP has been agreed and we were informed in January 2022 that safeguarding is on the reserve list. Work is taking place to agree the current Safeguarding Budget with Finance. October 2022 progress update - Finance anomalies on the budget have been rectified which has supported the re-write of the business case. Workforce advice has been obtained prior to submission to the Board Workshop. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve	

					monies for this financial year 2022-2023 Non recurring WG funding has been utilised to support out of hours BIA assessments and enhanced roles and responsibilities of existing staff – recruitment to specialist roles remains to be a challenge.	
	20957	Development of implementation plan in readiness for the receipt of the Mental Capacity Act – Liberty Protection Safeguards Code of Practice.	Michelle Denwood, Director of Safeguarding and Public Protection	31/05/2022	This will enable the organisation to be prepared for the receipt and implementation of the Liberty Protection Safeguards Code of Practice in the absence of a UK Government timeframe. October 2022 progress update - Delay due to UK and Welsh Government for release of the code of practice. Notification received from Welsh Government which has referenced dissemination of the Code of Practice as Winter 2023.	Delay
	21213	Utilise the agreed BCUHB IMTP funding application to support the	Michelle Denwood, Director of	31/10/2022	Enable implementation of the Social Services and Well-being Act to support the	Delay

		increased activity within Safeguarding.	Safeguarding and Public Protection		increased Deprivation of Liberty Safeguards and future Liberty Protection Safeguards activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. October 2022 progress update - Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The workforce advice is to be obtained prior to submission to Board Workshop. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve monies for this financial year 2022-2023	

	23066	Improve Mental Capacity Act awareness, training and reduction in DoLS 'backlog'.	Michelle Denwood, Director of Safeguarding and Public Protection	30/11/2022	Action Closed 24/10/2022. Welsh Government monies will support additional resource and educational tools to inform the workforce regarding capacity and harm which will reduce risk and improve patient care. October 2022 progress update - Action closed as evidence in place which identifies a reduction in the DoLS backlog by utilising Welsh Government monies. This activity remains under close monitoring arrangement and reports to Welsh Government on a quarterly basis. A new action for the monitoring of MCA training has resulted from the closure of this action as BCU continue to evidence low compliance with MCA mandatory training data.	Completed

	23505	Establish commissioning and governance arrangements for IMCAS as directed by the LPS code of practice. In line with WG guidelines ensure that there is suitable provision of IMCA services across the geographical area.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	The appointment of Independent Mental Capacity Advocates and delegated resource will ensure patients voice and choice will be heard and will be part of the legal considerations given to a patients Deprivation of Liberty. Additional IMCA's will support the LPS process and provide patients with an independent voice under the legal framework. Working with the six LA's provides assurance that all interested agencies are aware and engaged in the process. October 2022 progress update - BCUHB hold geographical responsibility for the provision of IMCA services, following receipt of WG monies the safeguarding team are working with the six Local Authorities and IMCA providers to increase service provision in line with WG	On track

					guidelines and national legislation.	
	23506	Establishment of operational groups to support the implementation of LPS within clinical and operational service delivery.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	To ensure that the service and function is embedded in front line practice. This will reduce unlawful detention and comply with the Code of Practice.	On track
	24304	Implementation of a task and finish group for Court of Protection DoLS within key community settings to ensure internal engagement to establish clear lines of accountabilities, escalation and governance.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	This will reduce the likelihood of unlawful detention relating to the directions of the court.	On track
	24305	Improve the implementation and understanding of the Mental Capacity Act (MCA) and improve MCA Mandatory training compliance.	Michelle Denwood, Director of Safeguarding and Public Protection	30/10/2023	Improve understanding and unlawful detention of service users. Update Position Training resource and a variety of materials are to be disseminated throughout the	On track

					organisation during Safeguarding Week 14th Nov. Enhanced Training Audit activities are to be identified.	
	TBC	Development of a Standard Operating Protocol (SoP) for assessing existing patients and for assessing future funded patients.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Safeguarding to engage in the development of a SoP to support to manage the complex process of Community DoLS and for the identification of patients who may be eligible for a CoP DoL authorisation. This will include General Practitioners (GP), District Nurses, Care Co-ordinators, Health Visitors and Commissioned Service Providers National NHS Health Board benchmarking has taken place. Engagement has taken place with L&RS to establish the legal position, accountability and responsibility in line with legislation. Engagement with	On Track

					Commissioning Services has commenced.	
	TBC	Develop, implement and trial a 7 Day Out of Hours MCA and DoLS advisory service utilising WG funding.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Utilise WG funding to ensure out of hours MCA and DoLS compliance amongst frontline services. Undertake audits of applications and BIA activity/performance within the trial period. Review the trial 7 day service to determine the long term requirements of services.	On track
	TBC	Embed regular documentation audits into practice to provide assurance that there is no delay in the quality or completion of DoLS applications.	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Updating current audit activity will ensure that the submitted DoLS and MCA documentation meets the requirements of the legal framework in line with the Deprivation of Liberty Safeguards legislation.	

					An improvement in the documentation submitted will reduce the time taken to process applications, reduce the time taken by front line staff having to amend or revisit documentation, and ultimately speed up the process of authorisation which will ensure compliance with the legal framework.	

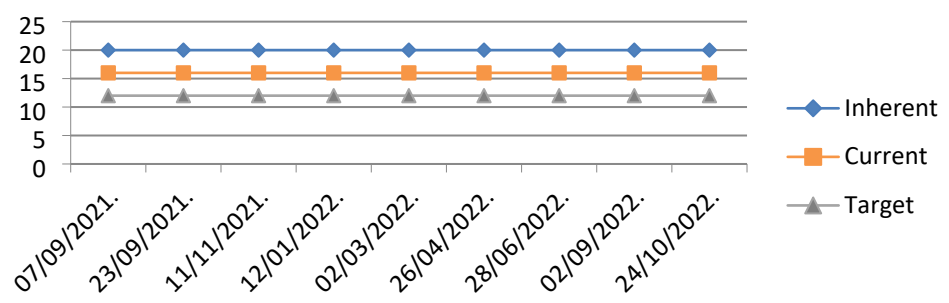
CRR21-15	**Director Lead:** Executive Director of Nursing and Midwifery.	**Date Opened:** 21 December 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 24 October 2022
	Risk: There is a risk that patients and service users may be harmed due to non-compliance with the Social Services and Well-Being (Wales) Act 2014	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 October 2023

There is a risk that patient and service users may be harmed due to non-compliance with the Social Services and Well-being (Wales) Act 2014 (SSWWA).

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 ,the Violence Against Women, Domestic Abuse, Sexual Violence [VAWDASV] in addition to 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 legislation and statutory 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 is in place and aligned to the National strategies which are regularly reported to Welsh Government. 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 Wales 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 have appointed the named Doctor for Safeguarding Children. A period of supervision and support is taking place due to the identified learning needs of the appointee. 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. SARC remains the accountability of the Central Integrated Health Community (IHC). 10. Fully engaged and supporting the Single Unified Safeguarding Review led by Welsh Government and the Home Office/Central Government for the re-write of Safeguarding and Homicide Reviews. 11. Monies secured and implemented for the role of Independent Domestic Violence Advocate in YG and YGC and WMH.	1. This risk is regularly monitored and reviewed at the Safeguarding Governance and Performance Group. 2. This risk is regularly monitored and reviewed at the local Safeguarding Forum meetings. 3. The risk is reviewed and scrutinised at the Executive Business Meeting. 4. This risk is regularly monitored and reviewed by participation in the safeguarding ward accreditation audit and analysis. 5. This risk is regularly monitored and reviewed by the statutory engagement with the North Wales Safeguarding Adults Board / 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, MHACCC and is reported into the Welsh Government.

12. Health Board Leading on Emergency Department Safeguarding Action plans to support the Health Inspectorate Wales [HIW] findings, recommendations and overarching HIW action plans reporting and monitored at the relevant Safeguarding Forums and to the Safeguarding Governance and Performance Group 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. 14. Targeted intervention for key areas ie. the 3 Emergency Departments and a number of identified wards and areas within Mental Health and Learning Disabilities is in place, with escalation taking place accordingly. 15. Temporary appointment to the position of Head of Safeguarding Business, Quality and Governance which has enabled engagement and discussions to ensure the Safeguarding agenda and Safeguarding Reporting Framework are reviewed to reflect and support the new Operational Model.	

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, Prevent 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 and the development of a Safeguarding Business Case. 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. 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, audit and utilising a survey monkey is to be developed and monitored by implementation plans. Targeted activity for low compliance and high risk areas.
6. A number of senior and operational posts remain vacant following recruitment, risk assessment are in place focusing upon service delivery and the identification of activities to ensure compliance and engagement.
7. IHC Safeguarding Forums are not consistently taking place, there is proactive engagement taking place with the chairs to review membership and the agenda including the cycle of business to ensure full engagement and escalation. This will be supported by the review of the terms of reference and reporting framework relating to the Safeguarding Governance and Performance Group (SGPG).
8. There is a lack of engagement at the Safeguarding Governance and Performance Group from the existing membership as a result of the new BCUHB Operating Model. Contact made with IHC Leads/Directors and Corporate Leads to ensure engagement in the revised Terms of Reference and Reporting Framework. A meeting is arranged with the Assistant Director of Governance to support this review.
9. The number of Child Practice Reviews/Adult Practice Reviews/Domestic Homicide Reviews have increased considerably, this places increased pressure upon the Team to allocate statutory membership and statutory participation. The newly appointed Head of Safeguarding Business, Quality and Governance is reviewing the Safeguarding Standard Operating Procedure (SoP) to strengthen and streamline governance and reporting and the identification of Trends. Processes are in place to ensure engagement and participation following National and Local procedures.
10. There is a lack of standardised engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team and the Safeguarding Team. The newly appointed Head of Safeguarding Business, Quality and Governance is agreeing a pathway and developing a Standard Operating Procedure (SoP) to ensure consistency, engagement and collaboration, this activity has commenced.
11. There is reduced engagement and embedded process agreed with HMP Berwyn regarding access by the prison clientel for NHS services and the management of risk and governance. The newly appointed Head of Safeguarding Business, Quality and Governance is developing a pathway and SoP to ensure consistency, engagement and collaboration with the prison service to ensure a framework is in place and is effective. Discussions have taken place to inform safeguarding of any current required engagement.
12 Audit data has shown there is a reduction in Statutory participation at MAPPA 2 and MAPPA 3 (Very High Risk Individuals) meetings by Corporate Safeguarding (Crime and Disorder Act 2014). This had resulted in immediate interim controls to be put in place but a review of the Safeguarding Standard Operating Procedure and awareness Training has commenced.

Progress since last submission
1. Controls in place updated to reflect current risk position. 2. Gaps in controls updated to reflect current risk position. 3. Action ID 18113 – Action remains delayed, National agreement still awaited. Professional Allegation/Position of Trust workplace group to be considered and developed in light of the delay Nationally and Regionally. 4. Action ID 18120 – Action delayed, the task and finish group has disseminated future dates to re-commence this work on a National footprint, first group meeting was held on the 26th October 2022, which replaced the intended meeting of the 18th October 2022. 5. Action ID 21216 - Action remains delayed with the Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The workforce advice has been obtained prior to submission to Executive Management Group. 6. Identification of new action ID 24306. As a result of the BCUHB new operating model the current Safeguarding Governance and Reporting Framework requires review and updating to ensure reporting and escalation is aligned to the new operating model. 7. Identification of new action - The increase in statutory Multi-agency Child and Adult Death Reviews has resulted in the need to review and to refresh the Safeguarding Standard Operating Procedure (SoP) to ensure appropriate engagement and the triangulation of themes and trends. 8. Identification of new action - There is a lack of standardised engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team. 9. Identification of new action - There is reduced engagement and an embedded process agreed with HMP Berwyn regarding access by the prison clientel for NHS services and the management of risk and governance. Engagement has commenced and dates agreed to progress with this work. 10. Identification of new action - Audit data has shown there is a reduction in Statutory participation at MAPPA 2 and MAPPA 3 (Very High Risk Individuals) meetings by Corporate Safeguarding, as required by the Crime and Disorder Act 2014. Immediate controls have been put in place and the Standard Operating Procedure and awareness training has commenced.

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

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	18113	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. October 2022 progress update - National agreement still awaited. Professional allegation/Position of trust workplace group to be considered and developed in light of the delay Nationally and regionally.	Delay
	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	Delay

					Organisational risks. October 2022 progress update - The task and finish group has disseminated future dates to re-commence this work on a National footprint, first group meeting was held on the 26th October 2022, which replaced the intended meeting of the 18th October 2022.	
	21216	Utilise the agreed BCUHB IMTP funding application to support 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 [Wales] Act 2014to support the increased activity. This is dependent on the approval and governance process as part of the Integrated Medium Term Plan. The Corporate Safeguarding IMTP has been agreed and we were informed in January 2022 that safeguarding is on the reserve list. Work is taking place to agree the current Safeguarding Budget with Finance.	Delay

					The delayed LPS Code of Practice has impacted upon the development and revised proposed Safeguarding Structure and Business Case. October 2022 progress update - Action remains delayed with the Finance anomalies on the budget have been rectified which has supported the re-write of the business case. The workforce advice has been obtained prior to submission to Executive Management Group. There is no availability on the December EMG agenda. The Business case will be submitted to the February 2023 Board Workshop. Informed there is no reserve monies for this financial year 2022-2023	
	23507	Mental Health &Learning Disability to include the identification of resource to	Michelle Denwood, Director of	31/03/2023	A single point of contact and physical presence will support the front line clinician to	On track

		support a Safeguarding physical presence within the Mental Health Units.	Safeguarding and Public Protection		identify and to safeguard service users who may be at risk of harm. Will support the implementation of safeguarding practice and training. This action has again been discussed with the interim Director of Nursing MHLD	
	24085	Review IHC/MHLD/Womens Safeguarding Forums Terms of Reference and the reporting framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that reporting and governance is in line with the organisations revised structure ensuring operational and strategic safeguarding activity is aligned to the organisations performance and risk management activities ensuring compliance with safeguarding legislation relating specifically to the NHS. Deadline for the return of comments for the Terms of Reference is 17th November 2022. Some responses have been received. Meeting taking place with the Associate Director of Governance and	On track

					Communication on the 11th November 2022.	
	24086	Monitor and review that Safeguarding Forums are convened in line with the Safeguarding reporting framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Ensure that the Safeguarding agenda is embedded and key areas of risk escalated within the identified Health Economies and Mental Health and Learning Disabilities. Meeting has already taken place with the IHC Associate Director of Nursing East who has agreed to trial the new agenda and exception reporting template for the Safeguarding Forum, this will take place in November. IHC Director of Nursing Central and West are meeting with the Head of Safeguarding Governance on the 16th November 2022	On track
	24306	Update and review Safeguarding Governance and Performance Group Terms of Reference and the Safeguarding Reporting Framework	Michelle Denwood, Director of Safeguarding and Public Protection	31/03/2023	Safeguarding Governance and Reporting activity will be in line with BCU's governance framework. This will ensure direct line of accountability remains with the Chief Executive and Safeguarding remains everyone's business. This will ensure risks are reduced and key activities	On track

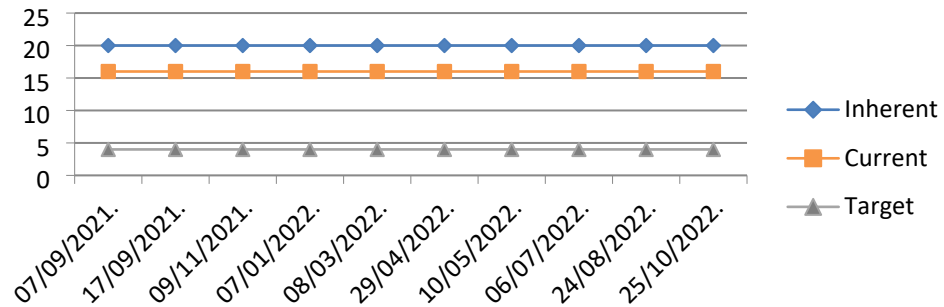
					obtain support and engagement. As a result of the BCUHB new operating model the current Safeguarding Governance and Reporting Framework requires review and updating to ensure reporting and escalation is aligned to the new model. This will be reviewed following a planned meeting with the Associate Director of Governance and Communication on 11th November 2022.	
	TBC	Ensure panel members, Chairs and Reviewers of Multi-agency Child and Adult Death Reviews have the necessary skills and expertise to engage and to ensure monitoring arrangements are embedded into the role and responsibilities.	Michelle Denwood, Director Of Safeguarding And Public Protection	31/09/2023	The newly appointed Head of Safeguarding Business, Quality and Governance is reviewing the Safeguarding Standard Operating Procedure (SoP) to strengthen and streamline governance and reporting and improve the identification of themes and trends. The Practice Development Lead is developing specialist	On track

					Training to support panel members and to increase the availability of BCUHB safeguarding specialist as the designated Chairs and Reviewers for complex multi-agency death reviews.	
	TBC	Improve the consistency of escalation and engagement with HIW/HSE/Complaints and Incident monitoring within IHCs and the Corporate Team with the Safeguarding Team	Michelle Denwood, Director Of Safeguarding And Public Protection	31/07/2023	The newly appointed Head of Safeguarding Business, Quality and Governance is agreeing a pathway and developing a Standard Operating Procedure (SoP) to ensure consistency, engagement and collaboration, this activity has commenced.	On track
	TBC	Improve and embedded processes agreed with HMP Berwyn relating to the access by the prison clientel of NHS services, to strengthen the management of risk, governance and communication.	Michelle Denwood, Director Of Safeguarding And Public Protection	30/06/2023	Engagement has commenced and dates agreed to progress with this work. Immediate safeguards are in place for HMP to notify where appropriate safeguarding.	On track
	TBC	Ensure and improve the statutory participation at MAPPA 2 and MAPPA 3	Michelle Denwood, Director Of	30/05/2023	Immediate controls have been put in place and the development of a Standard	On track

		(Very High Risk Individuals) meetings by Corporate Safeguarding, and MHLD as required by the Crime and Disorder Act 2014.	Safeguarding And Public Protection		Operating Procedure and a notification agreement with the MAPPA Co-ordinator. Awareness training has commenced.	

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:** 25 October 2022
	Risk: Non compliant with manual handling training resulting in enforcement action and potential injury to staff and patients	**Date of Committee Review:** 01 November 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. There is an increased risk due to mass recruitment of HCA's, Nurses leading to failure to deliver compliance.



	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 which includes Manual Handling. 2. Training plan is in place specifically in relation to Manual Handling, training compliance is monitored by the Mandatory training group.	1. Regular oversight and review by the Occupational Health & Safety Team.

3. Recruitment programme has been approved and is in place as part of the Health & Safety business case. 4. Risk assessments in place to provide safe training environment. 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. 6. Suite of fully functional training rooms secured. 7. Datix system is monitored daily by the Health and Safety team to review incidents and follow up on lessons learnt. 8. Multi-disciplinary team including Manual Handling representative set up and currently auditing compliance with patient handling risk assessments.	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.

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 56%. 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. Description of the risk reviewed and updated to reflect current position. 2. Controls in place reviewed to reflect current position. 2. Gaps in Controls reviewed and updated to reflect current position. 3. Recruitment of 3 Manual Handling trainers has taken place, however, this is to replace current vacancies.

4. Administration support for the Manual Handling team to monitor DNA's at training has taken place.
5. Gap identified as a result of the Health and Safety Executive investigation into facilities staff compliance with training, with the potential for a prosecution for the Health Board. Training package is in place to ensure facilities staff are suitable trained. This has now been addressed with 100% of facilities staff (currently in work) from within the identified area having now benefitted from the training. HSE have been informed of the compliance.
6. Action ID 17979 – Action remains delayed, Manual Handling Team manager commenced post on the 1st September, has since left the post on the 30th September. Recruitment out on the TRAC system for 2x band 6 manual handling advisors. With current post vacancies for advisors at 4.6. Band 4 trainers currently have 3 vacancies, these have been recruited to and are awaiting start dates.
7. Action ID 18859 – Action delayed, draft policy is in place, and a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 December 2022, the delay with this action is as a result of the vacant manager post. Ratification process will follow the completion of the policy review.
8. Action ID 23660 - Action now delayed as a result of the vacant manager post. The external trainer has continued to provide training following the trial in August 2022.
9. Action ID 24051 – Action closed, increase in the numbers of staff within the training sessions has taken place, 1-12 for both orientation and for refresher training and agreed with the trainers.

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	17979	Additional trainers sought, to be clinically trained as per the standards set	Mrs Susan Morgan, Head of	30/11/2021	Additional trainers to provide training to the standard set within the Passport for clinical	Delay

to achieve target risk score		within the All Wales Manual Handling Passport and Information Scheme that BCUHB have signed up to provide.	Health and Safety		qualifications. Having increased number of trainers allows for increasing classes that can be offered, increase attendance and compliance for BCUHB. October 2022 progress update - Manual Handling Team manager commenced post on the 1st September, has since left the post on the 30th September. Recruitment out on the TRAC system for 2x band 6 manual handling advisors. With current post vacancies for advisors at 4.6. Band 4 trainers currently have 3 vacancies, these have been recruited to and are awaiting start dates.	
	17980	Consider targeted training for both inanimate load handling and people handling. A training needs analysis to be completed, along with the use of Datix data to show high-risk areas to target for training.	Mrs Susan Morgan, Head of Health and Safety	01/04/2023	Target areas to ensure those with higher need for people handling training have been offered and can attend as priority. This should reduce the risk of injuries to both staff and patients if those who handle patients more-often have the appropriate training.	On track

					October 2022 progress update - In depth checks using the ESR system to identify staff sickness trends and high risk areas, this remain ongoing.	
	18859	Finalise, approve and implement Manual Handling Policy and Plan.	Mrs Susan Morgan, Head of Health and Safety	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. October 2022 progress update - Draft policy is in place, a review of the policy is underway in line with Health and Safety Executive recommendations. Following the review, the policy will be presented for approval, anticipated completion of the policy review by 30 December 2022, the delay with this action is as a result of the vacant manager post. Ratification process will follow the completion of the policy review.	Delay

	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. October 2022 progress update - Action now delayed as a result of the vacant manager post. The external trainer has continued to provide training following the trial in August 2022.	Delay
	24050	Muscular-skeletal disorder group to be re-instated to review trends in incidents and follow up improvement actions.	Mrs Susan Morgan, Head of Health and Safety	31/12/2022	Identify hot spot areas and to target those areas for intervention. October 2022 progress update - First Meeting held on the 6th October with Terms of Reference to be agreed moving forwards.	On track
	24051	SBAR to be developed to request authorisation to increase staff numbers in training sessions	Mrs Susan Morgan, Head of Health and Safety	31/10/2022	Action closed 25/10/2022 Increase the number of available seats and therefore increase the numbers of staff trained. October 2022 progress update - Increase in the numbers of staff within the training	Completed

					sessions has taken place, 1-12 for both orientation and for refresher training and agreed with the trainers.	

<table>
<tr><td rowspan="3">CRR21-17</td><td>Director Lead: Deputy Chief Executive Officer/Executive Director Of Integrated Clinical Services</td><td>Date Opened: 26 July 2021</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 09 November 2022</td></tr>
<tr><td 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: 01 November 2022</td></tr>
<tr><td>Target Risk Date: 31 March 2023</td></tr>
<tr><td colspan="3">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 Adolcent 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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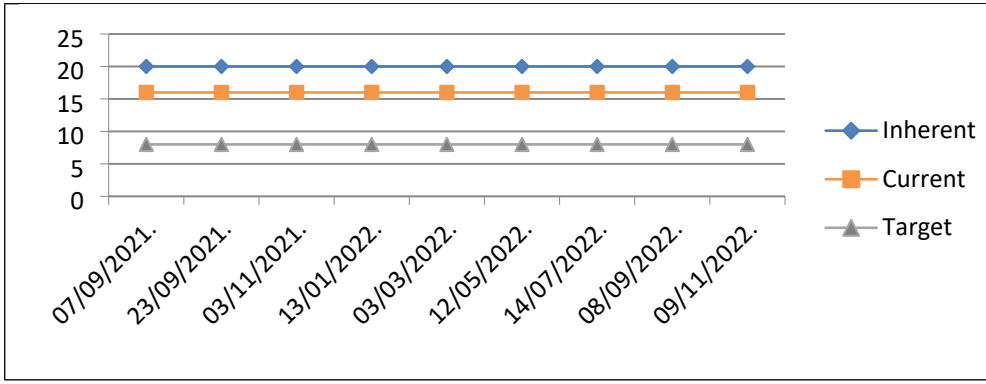


	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	**Assurances**
1. Child and Adolescent Mental Health Services (CAMHS) Operational Policy in place with oversight by each Integrated Health Community Team. 2. Collaborative working taking place between Mental Health, Emergency Departments, Paediatrics and Integrated Health Community 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. Access to Legal and Risk to support the Health Board when a young person has a Depravation of Liberty Safeguards in place via court of protection. 9. Safeguarding discharge Standard Operating Procedure for young people in place.	1. A scoping exercise or report of Child and Adolcent 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.

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.	

Gaps in Controls/mitigations
1. Inability to meet growing demand in crisis presentations due to availability, staff shortages and availability of appropriately trained staff. Currently working with recruitment agencies 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 and updated to reflect current risk position. 2. Gaps in controls reviewed to ensure relevance with current risk position. 3. Task and Finish Group set up looking at the s136 policy specifically in relation to Children and Young people and to review the escalation processes and produce a flow chart that will be clear and easy to follow. 4. Action ID 23091 - Action closed, Campaign has taken place, action closed, however there remains an ongoing issue in relation to vacancies which are being managed through locum staff. 5. Action ID 17956 – Action delayed, Crisis Intervention pathway. Priority focus on establishing CAMHS pathway to support 111+2 for mid-December. Crisis and Unscheduled Programme Group now established under CAMHS Targeted Intervention. 6. Action ID 17964 – Action closed, Training is being delivered and there is a schedule in place. Youth Mental Health First Aid has commenced roll out across the region and will be ongoing to April 2023. Further training requirements will be identified once the updated policy has been completed, and will become a BAU function. 7. Action ID 18334 – Action delayed, ongoing action, developed through the CAMHS Targeted Intervention, re-scoping and planning ongoing. The timescales for this requires extension.

8. Action ID 21236 – Action delayed, the recommendations have been embedded into the Crisis and unscheduled care workstream within CAMHS Targeted Intervention.

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

Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	17956	Multi-agency plan and policy for underpinning a robust Multi-agency Crisis Intervention pathway to be developed.	Marilyn Wells, Head of Nursing	31/10/2022	This will enable us to divert young people at the front door and support their needs in different ways. November 2022 progress update - Action delay, Crisis Intervention pathway. Priority focus on establishing CAMHS pathway to support 111+2 for mid-December. Crisis and Unscheduled Programme Group now established under CAMHS TI.	Delay

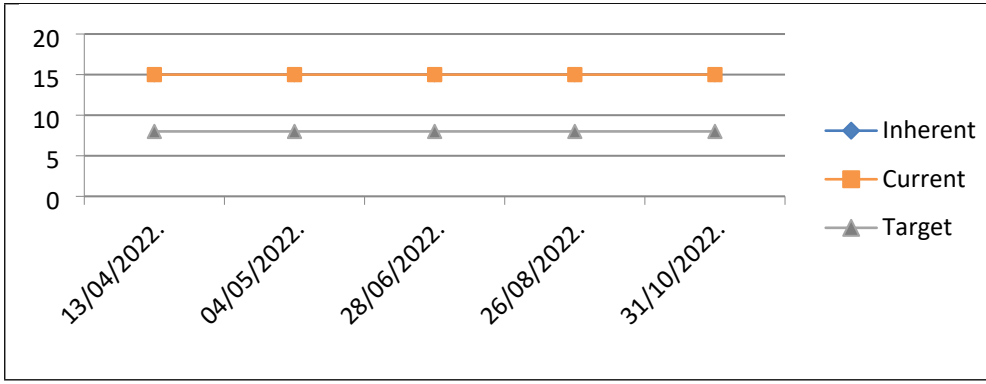
	17963	Task and Finish Group to review SCH03 Policy and update policy around care of young people at high risk of harm.	Marilyn Wells, Head of Nursing	31/12/2022	This will enable us to have a pathway in place and enable timely assessments without necessarily needing admissions. November 2022 progress update – T&F group established with 3 dates identified before the end of December 2022. Additional work is required to streamline existing guidance. There is a requirement to update MH2 first and then SCH03.	On track
	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. August 2022 progress update - Plans being developed to deliver training of youth Mental Health First Aid, this will be delivered within each Integrated Health Community, further work required to develop a rolling programme of training which will extend beyond the action due date. Training requirements are highlighted in the new NICE	Completed

					guidance and recommendation in relation to supervision for staff. November 2022 progress update – Action closed. Training is being delivered and there is a schedule in place. Youth Mental Health First Aid has commenced roll out across the region and will be ongoing to April 2023. Further training requirements will be identified once the updated policy has been completed, and will become a BAU function.	
	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. November 2022 progress - Ongoing action, developed through the CAMHS Targeted Intervention, re-scoping and planning ongoing. The timescales for this requires extension.	Delay
	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	Delay

					recommendations to support the development of high quality and safe care. August 2022 progress update - Implementation of recommendations remain ongoing. November 2022 progress update – The recommendations have been embedded into the Crisis and unscheduled care workstream within CAMHS Targeted Intervention.	
	23091	Progress with recruitment to bespoke campaign for Child psychiatry.	Mrs Louise Bell, Assistant Director CAMHS	31/10/2022	Action closed 09/11/2022 Implementation will help to deliver a safe and sustainable service within BCU. November 2022 progress update - Action closed, Campaign has taken place, action closed, however there remains an ongoing issue in relation to vacancies which are being managed through locum staff.	Completed

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:** 31 October 2022
	Risk: Inability to deliver timely Infection Prevention & Control services due to limited capacity	**Date of Committee Review:** 01 November 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 workloads 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.	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.

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. 8. Plan in place on how Infection Prevention can support the Infection Prevention Champions to help promote Infection Prevention with numbers growing each month.	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. Action ID 20654 – Action closed, plan in place, over 300 Infection Prevention champions now in place, continuing with sessions to increase this number across the Health Board. Action closed as this is now business as usual and an ongoing activity.

4. Action ID 20659 – Action delayed, awaiting for meeting to be set up with Finance to review current allocation due to not being aligned with current establishment.
5. Action ID 21696 – Action delayed, appointing at lower grade and providing training to staff members is in place and remains ongoing.

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

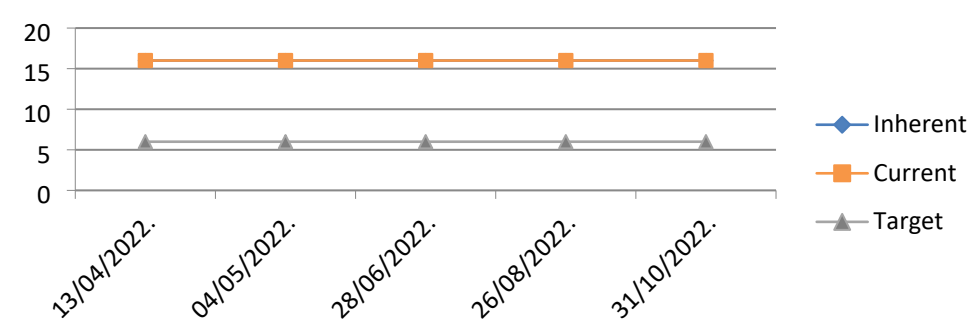
Risk Response Plan	**Action ID**	**Action**	**Action Lead/ Owner**	**Due date**	**State how action will support risk mitigation and reduce score**	**RAG Status**
Actions being implemented to achieve target risk score	20654	Use Infection Prevention Champions to promote good practice.	Mr Dafydd Williams, Infection Prevention Nurse	30/09/2022	Action closed 31/10/2022. To help promote IP in their own departments whilst visibility of the IP team will be low October 2022 progress update - Plan in place, over 300 IP champions now in place, continuing with sessions to increase this number across the Health Board. Action closed as this is now business as usual and an ongoing activity.	Completed

	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 that more staff are required and obtain approval for funding October - Awaiting for meeting to be set up with Finance to review current allocation due to not being aligned with current establishment.	Delay
	21696	Recruit to current vacant Infection Prevention posts	Mrs Andrea Ledgerton, Specialist Matron IP	30/09/2022	Fill current vacant posts October 2022 progress update - Appointing at lower grade and providing training to staff members is in place and remains ongoing.	Delay
	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
	22927	Promote Infection Prevention Massive Open Online Course education programme	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/01/2023	To improve knowledge, practice and compliance with IP in wards and departments. October 2022 update – Health Board have been informed there is a new	On track

					course lead at Bangor University and that the programme will recommence in the new year but no date has been given yet and there is now a waiting list to attend. A presentation slide has been updated for the October IPSG meeting to inform key stakeholders.	

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:** 31 October 2022
	Risk: Potential that medical devices are not decontaminated effectively so patients may be harmed.	**Date of Committee Review:** 01 November 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.	1. Regular review by Decontamination Group. 2. 6 monthly decontamination audits by Infection Prevention team.

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. 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.	3. Decontamination audits by Authorised engineers. 4. Sterile services departments have audits carried out by notified bodies in 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. Decontamination Group have met on the 25th August, with significant improvement in relation to the risk register entries, with work ongoing to further improve. 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. Control in place review to reflect current risk position. 2. Gaps in controls reviewed and updated to reflect current risk position. 3. Action ID 22149 – Action closed, meeting held with Head of Estates and the Hospital Management Teams in YGC and WM to highlight the findings of the Shared Services Strategy Report and highlight the issues at their hospitals. Requested they add key items to the capital programme for submission in October. Assistant Director Of Finance also updated. 4. Action ID 22153 – Action delayed, Shared Services report received and shared with all managers, Meetings to be arranged for November 2022 with the Estates teams. 5. Action ID 24069 – Action delayed, awaiting the start date for the newly appointed Decontamination Consultant who will lead on the action, anticipated start date is the 8th November. 6. Action ID 24070 – Action delayed, funding approved, recruitment of the post has taken place with a start date of the 8th November anticipated.

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	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.	On track

					The action will focus on policies and procedures due for review by the end of 2022.	
	22148	Purchase new washer disinfector for endoscopy unit at YG	Mrs Joanna Elis-Williams, Head of Secondary Care Office	31/03/2023	To provide resilience in the event of a machine failure and allow ENT scopes to be decontaminated October 2022 progress update - Capital bid has been submitted however anticipated delay to the action due date.	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	30/09/2022	Action Closed September 2022 To highlight key issues and establish a way forward September 2022 - Meeting held with Head of Estates and the Hospital Management Teams in YGC and WM to highlight the findings of the Shared Services Strategy Report and highlight the issues at their hospitals. Requested they add key items to the capital programme for submission in	Completed

					October. Assistant Director Of Finance also updated.	
	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. October 2022 - Group has reformed and is in the process of developing plans to address the funding required.	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 October 2022 - Shared Services report received and shared with all managers, Meetings to be arranged for November 2022 with the Estates teams.	Delay
	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
	24069	Establish a stakeholder group to review the Shared Services report	Ms Rebecca Gerrard, Director of Nursing Infection	31/10/2022	To make improvements to the decontamination facilities and infrastructure. October 2022 progress	Delay

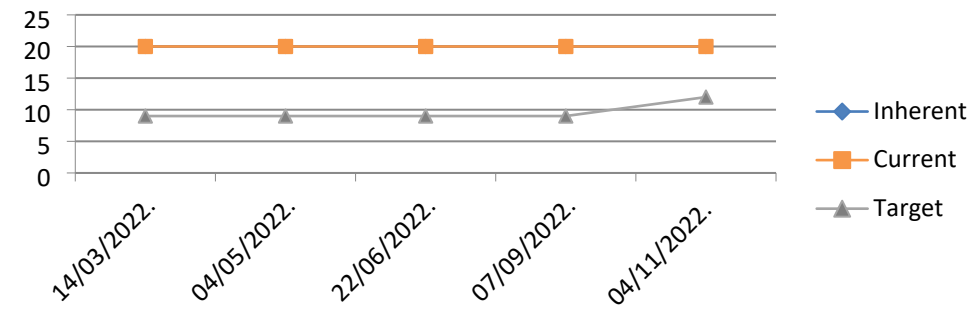
			Prevention & Decontamination		update - Awaiting the start date for the newly appointed Decontamination Consultant who will lead on the action, anticipated start date is the 8th November.	
	24070	Recruitment of an External Consultant to facilitate and progress the recommendations following the Shared Services report.	Ms Rebecca Gerrard, Director of Nursing Infection Prevention & Decontamination	31/10/2022	Develop a decontamination strategy and business cases and to ensure that the recommendations are fully implemented which will result in the improvement of the infrastructure and facilities for decontamination. October 2022 progress update - Funding approved, recruitment of the post has taken place with a start date of the 8th November anticipated.	Delay

CRR22-20	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 04 November 2022
	Risk: There is a risk that residents in North Wales may be unable to achieve a healthy weight as a result of wider determinents	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 31 December 2025

There is a risk that residents in North Wales may be unable to achieve a healthy weight and may become overweight and obese.

This may be caused by behaviours involving food intake, current circumstances, lack of physical activities, the living environment, food production and consumption, socio-economic factors and a lack of engagement with health professionals.

This may have an impact on or lead to unhealthy weight and obesity and place them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression.



	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. Continue to take a life course approach to implementing prevention based healthy weight initiatives which will report progress via a number of routes including the Healthy Weight Healthy Wales National Group, the BCU Population Health Group, and the Regional Partnership Group. 2. The continuation and further targeted development of 'Healthy Start' which provides vouchers for pregnant women and eligible families to buy milk, fruit, vegetables and pulses in local shops. 3. Continuation and further development of Maternity and Healthy Visiting Services supporting breastfeeding and weaning to support the Infant feeding Strategy, monitored via the North Wales Strategic Infant Feeding Group. 4. Community Dietetics Services will work with childcare provision embedding 'Tiny Tums' programme across all Early Years settings to encourage healthy, nutritious eating habits from early years. 5. Further supporting schools to take a 'whole schools' approach to health and wellbeing with a particular focus on diet through initiatives such as Come and Cook with your child and considerations regarding developing healthy eating habits and increased physical activity. 6. Let's Get Moving North Wales - a continuing programme encouraging residents of North Wales to move more often will operate alongside Sport North Wales, physical literacy development in schools and communities. 7. Continue to support the workforce to make healthy choices such as a balanced diet, active travel and moving more often through targeted campaigns and supportive services/infrastructure. Working with catering, dieticians, estates and occupational health colleagues to contribute to planning which considers these factors. 8. Further develop the whole system partnership approach to tackle risk factors through influencing priorities such as environmental planning and design, access to healthy food and active travel. 9. Further develop the links and access to Social Prescribing that encourages physical activity through partnership working with Primary Care, Local Authorities and Third Sector. Developing North Wales planned approaches and accessing intelligence regarding access and uptake via the Elemental software. Progress will be reported via	1. Risk is regularly reviewed at the Senior Manager`s meetings and at their local governance meeting. 2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. Escalation from Public Health Performance & Risk Management Group is to the Public Health Senior Leadership Team, with review by the Population Health Executive Delivery Group also. 4. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinatnts. 5. Prevention and Early Years National Programme - nationally funded. 6. Reporting progress to National teams (Public Health Wales/Welsh Government/Regional Partnership Board). 7. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25).

the Population Health Group, Primary Care groups and via the Well North Wales Programme (including Partner organisations).	

Gaps in Controls/mitigations
1. The risk requires System-wide approach to tackling the wider determinants of health. 2. The current Health Board provision is not operating at scale to meet the current and forecast needs of the population. 3. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years as is well documented through evidence and research. As a Health Board we will work with partners to implement the approaches (many of which are long term approaches) which support the strongest evidence base for success. 4. Part of the existing service provision is via non-recurrent and short term funding. 5. There continues to be some recruitment issues, re-evaluation of posts has taken place.

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. Proposal to amend the target risk score from 9 (Consequence x3 x Likelihood x3), to a 12 (Consequence x4 x Likelihood x3) to reflect the current social and economic conditions and factors. 3. Performance & Risk Management Group meet monthly as part of Public Health's governance and communications structure 4. Performance and Risk Management Group report to the Population Health Executive delivery group. 5. Business cases for weight services submitted as part of Integrated Medium Term Plan process.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	22372	Whole system approach to healthy weight	Ceriann Tunnah, Consultant in Public Health	31/03/2025	Taking a whole system approach to healthy weight will ensure that all partners are prioritising the issue of healthy weight and considering the impact of their decision-making on the population's ability to achieve a healthy weight. Obesity is a complex multi-factorial problem that requires a whole system approach. Key partners that are crucial to this work include spatial planners, transport providers, education providers, food providers, leisure providers etc. October 2022 progress update - Continuation of Full time public health team member working on whole system approach along with funding to support.	On track
	22373	Healthy Choices in the workplace	Ceriann Tunnah, Consultant in Public Health	31/05/2023	The working age adult population spend a significant amount of their time in the workplace. As a result it is crucial that we support workplaces to be health	On track

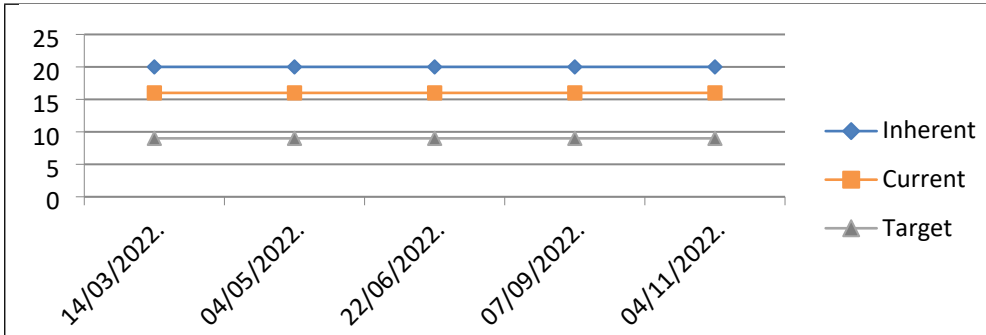
					promoting. This means ensuring staff have access to healthy food choices, equipment to make healthy meals, enough time away from work to prepare and eat a healthy meal. It is also crucial that the workplace supports their staff to remain active while at work as both diet and physical activity are crucial to achieving a healthy weight. October 2022 progress update - Continuation of the plan approved via Health Weight Health Wales and prevention on early years National funding.	
	22375	Social prescribing	Ceriann Tunnah, Consultant in Public Health	16/01/2023	Increasing physical activity levels is crucial in supporting people to achieve and maintain a healthy weight. One way that we can support people to do this for free is by promoting access to the natural environment. By doing this will also improve people's mental health as well as their physical health. This approach will also develop people's appreciation for nature and the need to protect it. One way of doing	On track

					this is to optimise access through social prescribing. October 2022 progress update - Received proposal from Local Authorities which contribute to delivering the outcomes identified within the project initiation document. Plans are moving into delivery phase.	
	22376	Pre-diabetes programme	Ceriann Tunnah, Consultant in Public Health	31/03/2025	By identifying patients who are at risk of developing diabetes and supporting them to access specialist weight management services we are taking a teachable moment opportunity and ensuring the patient is supported to improve their health and wellbeing. Primary care brief interventions are crucial in motivating people to change by implementing this programme across North Wales it is hoped more of the population who are overweight or obese will seek support to achieve and maintain a healthy weight.	On track
	22377	Weight management services	Ceriann Tunnah, Consultant in Public Health	31/03/2023	By ensuring those residents in North Wales who are overweight or obese can effectively access and engage	On track

					with specialist weight management services working alongside the remaining whole system approach we will start to reduce the overall prevalence of overweight and obesity in North Wales. October 2022 progress update - Continue to offer the services, tier 3 children's obesity service with tier 2 adult's in place and looking to expand the service. Range of ongoing projects within tier 1 funded through National funding streams as part of Healthy Weight, Health Wales and prevention and early years programme, and have contributed to the development of the Public Health communications plan.	

CRR22-21	**Director Lead:** Executive Director of Public Health	**Date Opened:** 26 November 2021
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 04 November 2022
	Risk: There is a risk that adults who are overweight or obese will not achieve a healthy weight due to engagement & capacity factors	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 31 December 2025

There is a risk that adults who are overweight or obese will not achieve a healthy weight. This could be caused by non-engagement with services or demand for services exceeding capacity.
This could impact on the health outcomes for these individuals by placing them at increased risk of Type 2 Diabetes, Cardiovascular disease, Cancer, Musculoskeletal conditions and low self-esteem and depression



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	4	16
Target Risk Score	3	3	9
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. Healthy Weight Healthy Wales funding to support with the implementation of the All Wales Adults Weight Management Pathway. 2. Additional investment in Foodwise for life for those residents with a BMI of 25-35. 3. The establishment of Level 2 weight management services through Foodwise for residents with a BMI of 25-35 and Slimming World vouchers for residents with a BMI of 30-35 with certain health conditions.	1. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinants. 2. Building a Healthier Wales Programme and Healthy Weight

4. The establishment of a Level 3 weight management service KindEating programme for residents with a BMI of between 35-45. 5. Investment in dedicated obesity leads within each of the LA National Exercise Referral programmes. 6. The establishment of a BCU Healthy Weight Healthy North Wales group to oversee the delivery of specialist weight management services.	Healthy Wales Programme (both nationally funded). 3. Reporting progress to National team (Public Health Wales/Welsh Government/Regional Partnership Board). 4. Progress on mitigating and managing risks reviewed locally via the Public Health Team and Health Improvement and Reducing inequalities Group (chaired by DoPH). 5. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25). 6. Confirmation of the Population Health Executive Delivery Group is now in place. The group will meet during July with review of Tier 1 risks in August.

Gaps in Controls/mitigations
1. The current provision does not meet the scale required to address current or forecast North Wales population requirements. 2. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years based on evidence and research. As a Health Board we will work with partners to implement the approaches which support the strongest evidence base for success. 3. Provision currently through National funding, with funding identified for 2 years, cost pressures for the health board if the national funding were withdrawn. 4. Recruitment pressures - lack of weight management workforce available - both ability to attract and numbers.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Assurance reviewed and updated to reflect current risk position. 3. Gaps in controls updated to reflect current position. 4. Actions reviewed and progress provided against the actions. 5. Business cases have been prioritised by the Population Health Executive Delivery Group. 6. Risk is reviewed and monitored at the Population Health Executive Delivery Group. 7. Business cases for weight services submitted as part of Integrated Medium Term Plan process.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

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	22357	Insight work	Ceriann Tunnah, Consultant in Public Health	31/03/2023	Insight work will enable us to improve outcomes for patients who were identified as overweight or obese. Factors that will be considered will include how patients access services, the intervention they receive and the factors that led to then disengaging. This information will allow us to design our weight management services to meet	On track

					the needs of patients achieve better outcomes i.e patients achieving a healthy weight and adopting healthy behaviours October 2022 progress update - There is an approved plan in place for the development of this work.	
	22358	pregnancy weight management service	Ceriann Tunnah, Consultant in Public Health	31/12/2023	Providing a weight management service during pregnancy will ensure that women are able to achieve a healthy weight during and after pregnancy and maintain their healthy behaviour postnatally. October 2022 progress update - In the process of delivering the plan.	On track
	22359	performance management dashboard	Ceriann Tunnah, Consultant in Public Health	31/03/2023	Developing a performance management dashboard will ensure that we are able to monitor the uptake of the service by population groups that are at increased risk of adverse outcomes from obesity. The dashboard will enable us to monitor both uptakes and outcomes by ethnicity, gender and deprivation decile	On track

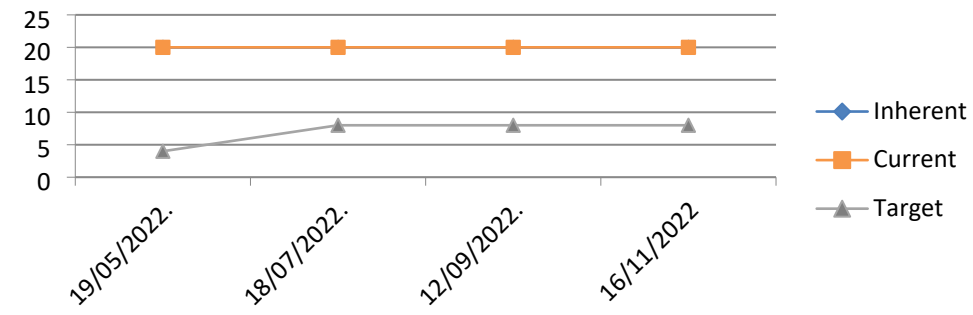
					October 2022 progress update - Development work continues, linking in with the national team at Public Health Wales and local informatics.	
	22943	Implement Healthy Weight Healthy Wales Programme Plan	Ceriann Tunnah, Consultant in Public Health	31/03/2024	Funded activity targeted at improving healthy eating habits and tackling obesity. October 2022 progress update - Approved by Welsh Government and funding identified to support the work, on track.	On track

CRR22-22	**Director Lead:** Executive Medical Director	**Date Opened:** 03 November 2020
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 16 November 2022
	Risk: Delivery of safe & effective resuscitation may be compromised due to training capacity issues.	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 December 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. 7. 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.	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 at the Resuscitation Committee via site reports. 3. The risk has been presented to PSQ (Performance Safety & Quality), and Clinical Effectiveness groups.

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 dedicated 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 investment (quotations have been provided to Central Integrated Health Care (IHC) teams) 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.

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. Plans drawn and quotations received for the required Estates works to provide dedicated training facilities for the Central Region. These plans have been provided to Central IHC with a request that funding is identified. Simultaneously Integrated Medium Term Plan submission has been progressed by the Resuscitation Services, but is awaiting an approval decision. 4. Reporting to the Executive Medical Director on the progress of the risk response and training trajectory information continues. 5. Meeting arranged to discuss the risk between the Executive Medical Director, Acting Deputy Executive Medical Director and the Resuscitation Services Senior Management Team set for the 29th November 2022. 6. Action ID 19313 – Action delayed with quotation received awaiting funding from either IMTP or the IHC. 7. Action ID 23208 – Action delayed with plans and costings received and shared, awaiting funding allocation. 8. Action ID 23754 – Action delayed as data collection in Central continues, Switchboard at the West site have a training date booked to begin their switch data collection.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Primary and community care Strengthen our wellbeing focus 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 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." November 2022 progress update – Quotation received awaiting funding from either IMTP or the IHC.	Delay
	23208	To identify funding stream for the required estates work by the Central Site Management with support from estates/Planning/Finance colleagues.	Alyson Constantine, Site Acute Care Director	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	Delay

					risk in the long-term. November 2022 progress update – Plans and costings received and shared, awaiting funding allocation.	
	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. November 2022 progress update – Data collection in Central continues, Switchboard at the West site have a training date booked to begin their switch data collection.	Delay

<table>
<tr><td rowspan="3">CRR22-23</td><td>Director Lead: Executive Director of Nursing and Midwifery</td><td>Date Opened: 02 April 2021</td></tr>
<tr><td>Assuring Committee: Quality, Safety and Experience Committee</td><td>Date Last Reviewed: 20 October 2022</td></tr>
<tr><td rowspan="2">Risk: Inability to deliver safe, timely and effective care - Wrexham Emergency Department.</td><td>Date of Committee Review: 01 November 2022</td></tr>
<tr><td></td><td>Target Risk Date: 09 January 2024</td></tr>
<tr><td colspan="3">There is a risk that patients attending Emergency Department (ED) would not be able to receive timely, safe and effective care. This is caused by overcrowding and reduced physical capacity due to delayes to transfer of patients awaiting specialty beds. This could lead to:
• Delay/inability to triage new attendants within 15 minutes of arrival as per national key performance indicators in line with Emergency Department Quality and Delivery Framework/Welsh Government Targets, deterioration in health/condition and increase level of harm including increased length of stay, level of intervention required and potential increase in mortality, breach of infection prevention measures and standards, which would increase spread of infection and/or potential outbreak.
•I nability to bring patients into the department from ambulances, detrimental impact to the community in terms of redeployment/response of ambulances, inability to meet privacy and dignity needs of patients, breach of performance measures as set out and monitored by Welsh Government, and pressure on the workforce, i.e. increase in workload due absences, difficulty in recruitment and retention of staff.
• Negative feedback / patient experience that is reflected via Health Inspectorate Wales and Community Health Council national reviews.
• On going risk of patients leaving without being seen further impacting on Welsh Ambulance SService Trust demand and patients deteriorating in the community after leaving without being seen.</td></tr>
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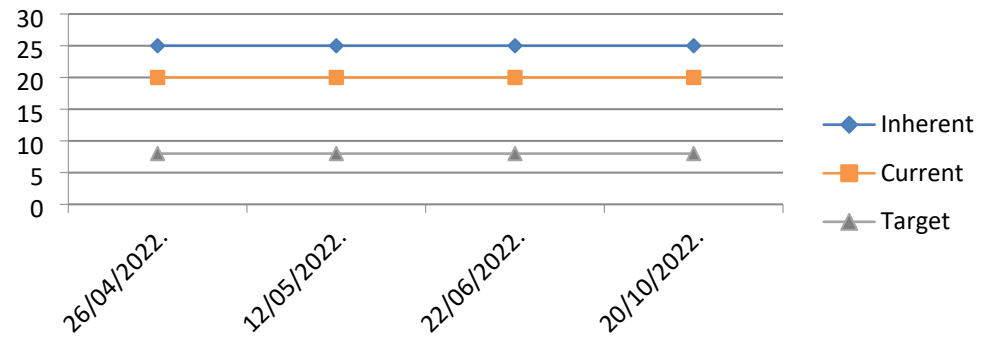


	Impact	Likelihood	Score
Inherent Risk Rating	5	5	25
Current Risk Rating	4	5	20
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in July 2022	Unchanged		

Controls in place	Assurances
1. Site escalation policy in place. 2. Emergency department escalation policy in place. 3. Infection prevention policy in place. 4. Welsh Government guidelines in place. 5. Standard Operating Procedure (SOP) for the management of patients held in ambulances outside ED. 6. Standard Operating procedure in place for triage of patients in relation to escalation of patients. 7. Matrons audit in place to identify areas i.e. welfare checks. 8. Additional health care support workers shifts generated to increase ability to perform welfare checks throughout the department with the increase volume of patients. 9. Screening process in place at point of entry to identify those at risk / suspected COVID with appropriate action taken.	1. Risk is reviewed at Emergency Care meeting and escalated to site Quality and Safety and Health and safety meeting. 2. Triage waits Key Performance Indicator data reported monthly through the Integrated Health Community (IHC) accountability meetings. 3. Report to Clinical Effectiveness Group. 4. Performance is monitored through harms, incidents, complaints and handovers. 5. Fortnightly reviews with Welsh Ambulance Service Trust of any harm/delays that may have occurred due to overcrowding.

Gaps in Controls/mitigations
1. Insufficient Capacity/physical environment to mitigate overcrowding, outpatients areas currently used for patients in the waiting room when minors are at capacity and all spaces blocked with patients waiting for beds. The plan moving forwards is to have a new minor injuries area co-located with urgent Primary Care Centre.

Progress since last submission
1. Description of the risk updated to reflect current risk position. 2. Controls in place reviewed and updated to reflect current risk position. 3. Gaps in controls reviewed and updated to reflect current risk position. 4. The department continues to identify incidents linked to the risk and link the incidents to the risk on the Datix system. 5. Action ID 19516 - Action closed with the action plan having been reviewed for Unscheduled care Improvement Group and action holders identified. 6. Action ID 20605 - Action remains delayed, the initial business case, whilst fully recruited to, has not provided the required numbers of Health Care Support Worker's to support the workload in the Emergency Department. Additional request to be submitted to the Integrated Health Community (IHC) management team for additional recruitment. 7. Action ID 21360 – Anticipated delay to the action due to delays with the project, likely to be until February 2023. 8. Action ID 23001 - Action closed as appointment of 8 locum Consultants have taken place and individuals will be starting between November 2022 and February 2023. In addition recruitment has taken place in line with the business case for the non-medical workforce. 9. Action ID 23002 - Action remains delayed due to the need to remove the pods from Acute Medical Assessment Unit which will increase the patient co-hort that can be directed to this area. Due to site pressures the surgical SDEC becomes bedded therefore restricting the ability to direct patients to the area.

Links to	
Strategic Priorities	**Principal Risks**
COVID 19 response Making effective and sustainable use of resources (key enabler)	BAF21-01 BAF21-14

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	19516	Review the action plan for Unscheduled care Improvement Group and identify action holders for updates.	Mrs Hazel Davies, Acute Site Director	30/09/2022	Action Closed 20/10/2022 This will de-congest ED of the excessive volume of patients who reside in Ed awaiting specialty beds Statistically we are seeing reduction in admission of high risk patient group and improved ambulance waits October 2022 progress update - Action completed with the action plan having been reviewed and action holders identified.	Completed
	20605	Increase establishment for additional Health Care Support Workers	Mrs Rachel Bowen, Deputy Head of Nursing EC	30/09/2022	This will increase availability of un-registered workforce to support registered workforce in providing safe and effective care to patients in ED. October 2022 progress update - Action remains delayed, the initial business case, whilst fully recruited to, has not provided the required	Delay

					numbers of Health Care Support Worker's to support the workload in the Emergency Department. Additional request to be submitted to the Integrated Health Community (IHC) management team for additional recruitment.	
	21360	Increasing the footprint of ED to manage overcrowding to protect the minor injury stream (WMH)	Mrs Hazel Davies, Acute Site Director	01/12/2022	It will enable relocation of the minor stream of patients in ED to an alternative area which will reduce overcrowding within the department. October 2022 progress update - Anticipated delay to the action due to delays with the project, likely to be until February 2023.	On track
	23001	Ongoing recruitment to the approved Workforce Business Case.	Bloor, Mrs Lindsey Bloor, Directorate General Manager	31/08/2022	Action Closed 20/10/2022 This will support staffing in additional areas of ED once available October 2022 progress update - Action closed as appointment of 8 locum Consultants have taken place and individuals will be	Completed

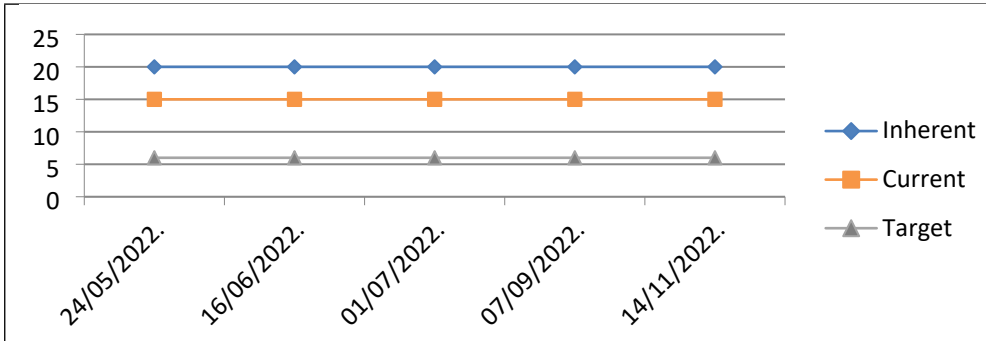
					starting between November 2022 and February 2023. In addition recruitment has taken place in line with the business case for the non-medical workforce.	
	23002	Increase the number of ambulant patient at Ambulatory Emergency Care/ Same Day Emergency Care (SDEC)	Bloor, Mrs Lindsey Bloor, Directorate General Manager	16/09/2022	This will reduce the number of patients in ED waiting room October 2022 progress update - Action remains delayed due to the need to remove the pods from Acute Medical Assessment Unit which will increase the patient co-hort that can be directed to this area. Due to site pressures the surgical SDEC becomes bedded therefore restricting the ability to direct patients to the area.	Delay

CRR22-24	**Director Lead:** Executive Director of Workforce and Organisational Development	**Date Opened:** 04 April 2022
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 14 November 2022
	Risk: Potential gap in senior leadership capacity/capability during transition to the new Operating Model.	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 31 March 2023

There is a risk of senior leadership capacity & capability gaps during the transition to the new Operating Model as people depart the organisation through the VERS process and the challenges recruiting people to new posts (internally and externally) during the transition phase when all key posts have been filled.

This has been caused by the delay to the organisational change process resulting in a divergence of parallel actions relating to those individuals leaving the organisation via VERS, the subsequent vacant posts and the recruitment to the new posts. The default position is to use the mechanism of internal backfill. Where a suitable individual cannot be identified then the posts will need to fill by external subject matter experts on an interim basis.

This may lead to a slowdown in the decision making processes as decision and action delivery defaults up to the next level in the responsibility and accountability framework.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	3	5	15
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. For the small number of posts which will become vacant the default option will be to look internally for people who can step-up on a short-term interim basis. Acting arrangements being agreed with Executives as a mitigation. Where this is not possible will look to use experienced external interims. 2. The management oversight of the transition for those and induction of new teams members is a critical role of the programme of work called: How We Organise Ourselves and the project group called the roles and the people. Arrangements have developed for these leaving the Health Board including the Operational Transition Plan and Leaving Well Handover Guide & Repository. These products along with a suite of induction and network products will support new people and emerging teams with knowledge transfer. 3. The transition of affected departments will be overseen by Executive Directors between April and March 2023. There will be additional management oversight of the How We Organise Ourselves programme, as well as the 'Roles and People' project team.	1. Risks are reviewed every 4 weeks by the Risk Management Group (Board and Director level).

Gaps in Controls/mitigations
1. Capacity of Executive Directors to respond to rapid decision making requirements. How We Organise Ourselves now has a regular weekly slot on the Executive Team agenda. Weekly Divisional Q&A sessions with Chief Executive Officer, Executive Director of Integrated Services / Deputy CEO and Executive Director of Workforce and Organisational Development provides a route for rapid escalation. 2. The management of the East, Central and West Integrated Health Community Operational Transition project plans through weekly status meetings and the connectivity to the Programme Leader Group provides a route for rapid escalation of possible gaps. 3. Demand for interim roles across the UK health sector could out-strip supply - therefore we are working closely with our agency partners to ensure we have access to the widest pool of capable individuals. 4. An early go-live date could result in vacant new posts where backfill arrangements are not appropriate as those who are acting up into existing posts will have been appointed to their new role and the interim contract period could be too short to attract interested parties - each post will be reviewed and the appropriate mitigation solution put in place.

Progress since last submission
1. Risk description reviewed to reflect current risk position. 2. Controls in place reviewed ensure relevance with current risk position. 3. Gaps in controls reviewed to ensure relevance with current risk position. 4. Action ID 23333 – Action closed as all substantive posts holders have been appointed. Where applicable interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders. 5. Action ID 23334 – Action closed as selection and appointment process now complete. 6. Action ID 23335 – Action delayed, selection process taking place on 11 & 14 November 2022. 7. Action ID 23336 – Action closed, with selection and appointment process now complete. 8. Action ID 23337 – Action delayed, selection process taking place on 11 & 14 November 2022. 9. Action ID 24129 – Action closed as substantive posts holder have been appointed. An interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders. 10. Action ID 24130 – Action delayed, suitable candidate not identified. Post renamed to Chief Operating Officer and re-advertised.

Links to	
Strategic Priorities	**Principal Risks**
Effective alignment of our people (key enabler)	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	23333	Set-up external selection process for Integrated Health Community Director roles (format, panel representation) (If required).	Lesley Hall, Assistant Director – Employment Strategies & Practices	25/07/2022	No gaps in senior leadership roles **November 2022 progress update**	Completed

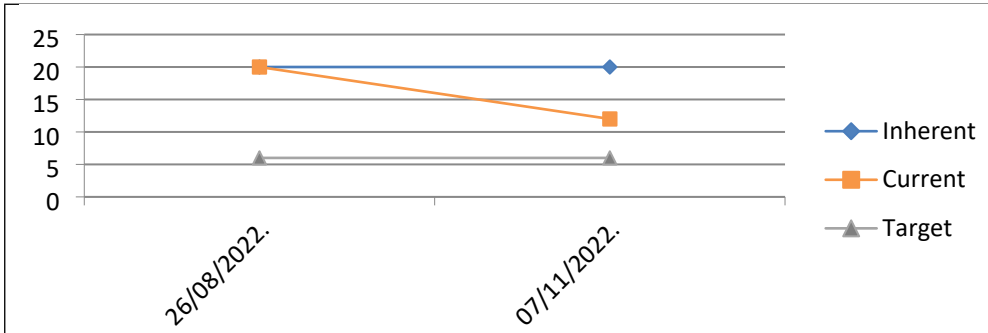
					All substantive posts holders have been appointmented. Where applicable interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders	
	23334	Set-up internal selection process for Senior Nursing posts (format, panel representation).	Lesley Hall, Assistant Director – Employment Strategies & Practices	27/06/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update** Selection and appointment process now complete.	Completed
	23335	Set-up internal selection process for Senior Medical posts (format, panel representation).	Claire Wilkinson, Deputy Director - Operational Workforce	30/12/2022	No gaps in senior leadership roles - **November 2022 progress update** Selection process taking place on 11 & 14 November 2022	Delay
	23336	Set-up external selection process for Senior Nursing posts (format, panel representation) (If required).	Lesley Hall, Assistant Director – Employment Strategies & Practices	01/08/2022	No gaps in senior leadership roles -interim/acting up arrangement in place	Completed

					November 2022 progress update Selection and appointment process now complete.	
	23337	Set-up external selection process for Senior Medical posts (format, panel representation) (If required).	Claire Wilkinson, Deputy Director - Operational Workforce	30/12/2022	No gaps in senior leadership roles **November 2022 progress update** Selection process taking place on 11 & 14 November 2022	Delay
	24129	Set-up internal selection process for Deputy Director posts – Regional services and Primary Care (format, panel representation).	Lesley Hall, Assistant Director – Employment Strategies & Practices	31/10/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update** Substantive posts holder have been appointmented. An interim(s) has been appointed to cover the gap between appointed and start date of the permanent post-holders	Completed
	24130	Set-up external selection process for Deputy Director posts – Regional services and Primary Care	Lesley Hall, Assistant Director – Employment Strategies & Practices	30/12/2022	No gaps in senior leadership roles – interim/acting up arrangement in place **November 2022 progress update**	Delay

		posts (format, panel representation) (If required).			Suitable candidate not identified. Post to be re-named Chief Operating Officer and re-advertised.	

CRR22-25 – Risk De-escalated to Tier 2 level.

CRR22-25	**Director Lead:** Executive Medical Director	**Date Opened:** 20 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Risk of failure to provide full vascular services due to lack of available consultant workforce	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 March 2023
There is a risk that there will be delays in the delivery of emergency, urgent and routine care for vascular patients. This is caused by to lack of consultant workforce which has impacted on services recently and meant only emergency and urgent services can be provided for a short period of time. Business Continuity plans are not adequate to mitigate and patients may need to be transferred NHS England for the the provision of urgent and emergnecy services.		



	Impact	Likelihood	Score
Inherent Risk Rating	5	4	20
Current Risk Rating	4	3	12
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. There are business continuity meetings occurring (between 3 and 5 times weekly) with all relevant operational teams 2. Action plans and decision logs are being maintained and reported to Exec Team daily. 3. Consultant Workforce Rotas are monitored on a daily basis forecasting risks and mitigations put in place	1. Regular review through the 3-5 times weekly vascular operational planning meetings (which feed directly to the Executive Medical Director and be reviewed via Quality, Safety and Experience Committee.

4 records of cancelled procedures are being kept and the risk of patient harm due to those cancellation being monitored. 5. External communication to Community and Primary Care outlining management and referral of routine, urgent and emergent patients 6. Further contingencies are being planned for potential additional complications which may lead to diversion of services to NHSE, including the number of emergency and urgent patients 7 Daily Monitoring of gaps in rota. (Consultant rota as normal from 01/08/2022) from 01/08/2022 Agency Locum commencing to support 1 x long term sickness, restricted practice and dual operating. 8. Further contingency to be agreed with Executive Medical Director in relation to diversion of potential aortic emergency to another Organisation.	

Gaps in Controls/mitigations
1. There is diminished resource across operational, governance, network and clinical teams in order to maintain any traction on day to day service running, planned improvements, action plans, and transformational change in addition to this work.

Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Proposal to extend the target risk date from the 31/10/2022 to the 31/03/2023 to allow sufficient time for building a contingency plan with NHS England to support the provision of Vascular Services. 3. Proposal to de-escalate the risk from the current score of 20 (consequence 5 x Likelihood 4) to a score of 12 (Consequence 4 x Likelihood 3) and the risk to be managed at a Tier 2 level. Since the escalation of the risk where the workforce was diminished due to sickness and annual leave, the service is now running at full capacity with 6 permanent consultants in post and 3 locum consultants in addition, the middle grade tier has been established to cover 9am to 5pm, across the sites 7 days a week. For YGC from Monday the 14th November 2022 there will be 24/7 cover of middle grades.

4. Action ID 23819 - Action closed, business continuity meetings have been running with gold command structure to ensure safe provision of service. These will be stepped down with Executive approval in November 2022.
5. Action ID 23999 - Action closed, this is managed as business as usual through surgical operation team processes.
6. Action ID 24000 - Action closed, dual on call for AAA continues in the event that Vascular service cannot provide dual on call, patients who require urgent or emergency AAA surgery would be transferred to Stoke Hospital. Complex surgery continues to be provided by Liverpool Vascular Services.
7. Action ID 24001 – Action delayed, The service is now able to provide a full Vascular service with 9 doctors working at Consultant level, work continues in building a contingency plan with NHS England to support the provision of Vascular Services and to build partnerships with larger Vascular service in England to ensure a more sustainable future service. Anticipated to have an agreed support through NHSE by 31/03/2023.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

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	23819	Develop local business continuity plans with Hub and Spoke Site Directorate Managers	Mrs Elaine Hodgson, Deputy Directorate General Manager	26/07/2022	Action closed 07/11/2022 Provide appropriate escalation and plans to mitigate risks Work is in progress, all three General Managers across each site are currently working on the business continuity plan. October 2022 progress update	Completed

					- Action closed. Business continuity meetings have been running with gold command structure to ensure safe provision of service. These will be stepped down with Executive approval in November 2022.	
	23999	Daily review of all overdue patients to ensure urgent patients are recognised and discussed with clinicians to ensure no harm due to delay in treatment	Ms Jenny Farley, Vascular Network Director	31/08/2022	Action closed 07/11/2022 Ongoing daily reviews to ensure no harm due to delay in treatment October 2022 progress update - Action closed. This is managed as business as usual through surgical operation team processes.	Completed
	24000	Chief Medical Officers Meetings with HB Executive Medical Director to discuss where support can be offered from in the event of inability to provide emergency and time critical care.	Ms Jenny Farley, Vascular Network Director	31/08/2022	Action closed 07/11/2022 Agreement with Liverpool (LiVES) Vascular services to support MDT decision making to ensure patients are prioritised Work in progress with Stoke Hospital to receive Urgent and Emergency Patients if required. October 2022 progress update	Completed

					- Action closed. Dual on call for AAA continues in the event that Vascular service cannot provide dual on call, patients who require urgent or emergency AAA surgery would be transferred to Stoke Hospital. Complex surgery continues to be provided by Liverpool Vascular Services.	
	24001	Identifying all vascular patients on the waiting lists and prioritising in the event of all day-case and outpatient services need to be transferred out to England	Jenny Farley Vascular Network Director	31/08/2022	The service is now able to provide a full Vascular service with 9 doctors working at Consultant level. 3 x weekly meetings with each site to report any urgent or time critical patients that require escalation for clinical intervention. October 2022 progress update. Exec approved data has been provided to NHSE and work continues in building a contingency plan with NHS England to support the provision of Vascular Services and to build partnerships with larger Vascular service in England to ensure a more sustainable future service. Anticipated to have an agreed	Delay

					support through NHSE by 31/03/2023.	

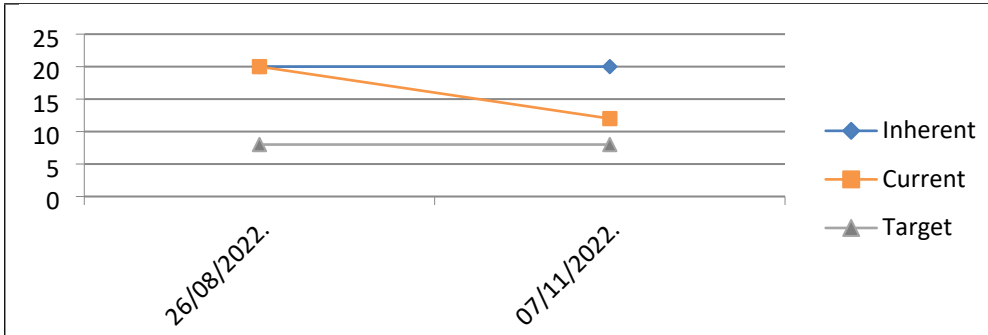
CRR22-26 – Risk De-escalated to Tier 2 level.

CRR22-26	**Director Lead:** Executive Medical Director	**Date Opened:** 29 July 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Risk of significant patient harm as a consequence of sustainability of the acute vascular service	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 31 December 2022

There is a risk that the acute vascular service may not be sustained.

This is caused by a reduction in the consultant workforce (sickness/vacancies) and the need for dual operating which requires two consultants to be available on call 24/7.

This could impact on the safety of care for time critical patients.



	Impact	Likelihood	Score
Inherent Risk Rating	4	5	20
Current Risk Rating	4	3	12
Target Risk Score	4	2	8
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	**Assurances**
1.Reintroduction of dual consultant operating (for aortic patients only) 2.Implementation of a focussed recruitment plan 3. Enhanced MDT oversight by a specialist centre.	1. Additional support during the AAA operation to limit risk of complications

4.Implementation of the vascular improvement plan (following Royal College of Surgeons review) 5.Contingency planning should the staffing levels fall below acceptable levels (maximising non consultant roles to support patient care and the use of agency) 6.Ongoing risk assessment of the waiting list in line with clinical priority 7. Work in progress to out-source time critical patients including renal.	2. Reduces the reliance agency locums and doctors without a consultant level qualification 3. Ensures that expert skills are agreeing on the most effective procedures for patients and timely decision making, and record keeping 4. Evidences the RCS recommendations are being actioned 5. Ensures Operational Team are fully aware of the patients to prioritise for emergency or time critical transfers to other hospitals and which patient conditions can be managed safely by other vascular/renal/diabetic teams internally. 6. Ensures that patients are prioritised on their clinical need and the most urgent patients waiting time deadlines are adhered to for timely treatment 7. Prevents delays to time critical treatments.

Gaps in Controls/mitigations
1. High sickness and annual leave reduces the ability for dual operating and potentially short notice 2. Poor reputation of service makes recruiting to consultant posts challenging, plus geography of the Health Board 3. Delays in patient decision making when insufficient MDT members attend the MDT 4. 100 + actions, plus actions from the Vascular Quality Panel review, insufficient workforce to support the delivery of the actions in a timely manner 5. May happen at such short notice that immediate transfer of emergency and urgent patient is required with limited notice for NHS England providers

6. Waiting List size significant post Covid, with little capacity to manage anything other than emergency and time critical urgent patients

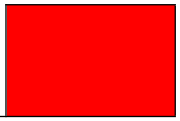
Progress since last submission
1. Controls in place reviewed to ensure relevance with current risk position. 2. Proposal to de-escalate the risk from the current score of 20 (consequence 5 x Likelihood 4) to a score of 12 (Consequence 4 x Likelihood 3) and the risk to be managed at a Tier 2 level. Since the escalation of the risk where the workforce was diminished due to sickness and annual leave, the service is now running at full capacity with 6 permanent consultants in post and 3 locum consultants in addition, the middle grade tier has been established to cover 9am to 5pm, across the sites 7 days a week. For YGC from Monday the 14th November 2022 there will be 24/7 cover of middle grades. 3. Action ID 24007 – Action delay, business continuity plans continue through the gold command structure, vascular service now fully supported by 9 consultants (6 permanent and 3 locum posts) in addition, 7 day middle grade rota in place across all 3 sites with plans form the 14th November to have 24/7 cover for the hub site. 4. Action ID 24009 – Action delay, Contract agreed with Stoke in the event that the Health Board Vascular service cannot provide time critical AAA treatment. Permanent contract negotiations are ongoing in addition to the established contract with Liverpool Vascular Service.

Links to	
Strategic Priorities	**Principal Risks**
Recovering access to timely planned care pathways	BAF21-02

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	24004	Additional funding requested to ensure	Ms Jenny Farley, Vascular	31/12/2022	All consultant vacancies recruited to (with the exception of the CD post interviews	On track

to achieve target risk score		effective medical and therapy workforce model	Network Director		august 2022). Ensures consistently safe patient care across all three sites. Reduces the reliance on agency workforce October 2022 progress update - IMTP has approved £5.8m funding for Vascular and Diabetic services which will enhance the current workforce, recruitment has commenced.	
	24006	Vascular Improvement Plan lead in post and Vascular Network Director in post for wider transformation	Ms Jenny Farley, Vascular Network Director	31/12/2022	Supports the co-ordination of actions needed to deliver against the recommendations. Ensures regular updating of the improvement plan Longer term transformation of the services for stability October 2022 progress update - Vascular network team now includes nursing governance operational transformational interim support until the 31/03/2023, 9 vascular consultants, 7 day cover in place for middle grades across all 3 sites.	On track
	24007	Business Continuity planning in place	Mrs Elaine Hodgson,	30/09/2022	Ensures all risks are identified and mitigated to support patient	Delay

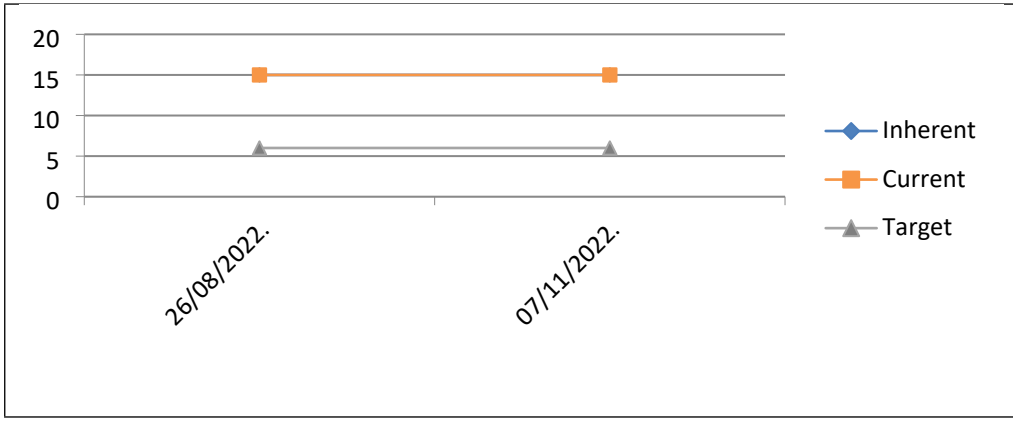
			Directorate General Manager		safety, enables immediate response to crisis Away Day agreed for the 16th September to complete business continuity plan. October 2022 progress update - Business continuity plans continue through the gold command structure, vascular service now fully supported by 9 consultants (6 permanent and 3 locum posts) in addition, 7 day middle grade rota in place across all 3 sites with plans form the 14th November to have 24/7 cover for the hub site.	
	24009	Working with NHSE to support the potential transfer of time critical patients to other service providers	Ms Jenny Farley, Vascular Network Director	30/09/2022	Ensures treatment of time critical patients Will help to develop a future service model to include service provision in England. October 2022 progress update - Contract agreed with Stoke in the event that the Health Board Vascular service cannot provide time critical AAA treatment. Permanent contract negotiations are ongoing in	Delay

					addition to the established contract with Liverpool Vascular Service.	

CRR22-27	**Director Lead:** Executive Medical Director	**Date Opened:** 31 January 2022
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 07 November 2022
	Risk: Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services.	**Date of Committee Review:** 01 November 2022
		Target Risk Date: 28 April 2023

There is a risk that the Vascular medical workfroce documenation is non-compliant with regulatory standards for recording keeping.

This could impact on patient outcomes, patient safety, reputation of the service, poor patient experience and clinical staff fitness to practice.



	Impact	Likelihood	Score
Inherent Risk Rating	3	5	15
Current Risk Rating	3	5	15
Target Risk Score	3	2	6
Risk Appetite	low level		1-8
Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Weekly case note audits in YGC are undertaken to monitor standards of record keeping actions are taken when poor documentation is identified 2. During the MDT meeting the audit results are fed back monthly. This had demonstrated a significant improvement in the standard of record keeping	1. All actions relating to this risk are included on the RCS Vascular improvement plan reviewed monthly at the Vascular Steering Group which feeds into Quality, Safety, and

3. Refresher training on consent has been provided between March and May 2022 from HIW and the GMC. 4. We continue with the pilot scheme for “CITO” an electronic MDT proforma and work continues to identify if this as an effective document repository. 5. MDT forms process of being filed by MDT co-ordinator in the notes on the same day. 6. Funding MDT admin support have been approved, and work is in progress to get those posts in place. 7. Clinical Governance admin support has also been approved, Job descriptions has been completed 8. Handover from not vascular surgical nigh on call teams	Experience Committee, and then Board

Gaps in Controls/mitigations

1. Permanent ward clerk to file in patient records including MDT outcomes documentations (temporary arrangements in place)
2. The pilot for Cito only covers MDT documentation. (HB wide issues)
3. There is no electronic system to cover daily ward round progress notes (HB wide issue)
4. Currently the surgical on call team has no electronic access to the vascular inpatient list which impacts on the ability to update the list for the vascular team (mitigated by oral handover)

Progress since last submission

1. Controls in place reviewed to ensure relevance with current risk position.
2. Appointment of the clinical director of Surgery to lead Vascular Services.
3. Appointment of clinical lead for a vascular on the 10th November 2022 to support the Vascular Services.
4. Additional PAs have been approved for governance, workforce and training and development for medical staffing, as well as developing closer links to the University for medical teaching.
3. Weekly audits continue to be reported monthly through the Vascular steering groups, chaired by the Medical Director.
4. Action ID 24076 – Action delayed as the pilot CITO continues with the MDT process.
5. Action ID 24078 – Action delayed, medical teams have devised a single communication document to enable clarity on all communications undertaken between medical teams and patients. Work continues to have a similar process for nursing and

therapy teams. Nursing workforce shortages have delayed the implementation. The appointment of a vascular network nursing and governance lead will provide the leadership required to progress this with the aim of having a process in place where communication is captured in one single place, anticipated by 31/01/2023. 6. Action ID 24079 – Action delayed, Intermediate Medium Term Plan funding will allow the appointment of a band 5 governance co-ordinator to support the management of governance processes. The funding has been approved for a National Vascular register inputter, which will support adequate reporting to the National register for Vascular procedures. Interim Network nursing and governance lead has been appointed to support implementation of all governance procedures and processes as well as service re-design of the current clinical governance pathways. 7. Action ID 24080 - Anticipated delay to the action due date, there has been no permanent ward clerk who is responsible for filing in place, which has delayed the ability to provide training. Although temporary support is in place.

Links to	
Strategic Priorities	**Principal Risks**
Transformation for improvement (key enabler)	BAF21-02

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	22282	Reference to RCS vascular improvement plan	Mr Laszlo Papp Newly appointed Clinical Lead	31/12/2022	The actions aim to further identify issues, complete weekly audit for assurance of improvement, provide standardised documentation such as clerking and ward round documentation to prompt quality, involvement of regulatory bodies for training, 1:1 meetings with clinicians to review audits results and	On track

					improvement requirements. The RCS action plan is informed by 2 stages of RCS review, NVR report and internally identified issues. There is a large number of actions assigned to improvement for documentation / consent processes which is kept up to date and reported on monthly. This is an ongoing activity. There are objective signs that the Consent process and note keeping standards have gone up.	
	24076	Pilot CITO as part of MDT	Hans Desmarowitz Vascular Governance lead	31/10/2022	To ensure legible documentation. Enhancing security and patient data storage. October 2022 progress update - Pilot CITO continues with the MDT process. November CITO pilot continues indefinitely at present	Delay

	24078	Ward Teams working with Patient Experience teams to develop holistic communication processes for documentation and for sharing with patients	Ms Jenny Farley, Vascular Network Director	31/10/2022	Will ensure holistic approach to patient care, will improve communication October 2022 - Medical teams have devised a single communication document to enable clarity on all communications undertaken between medical teams and patients. Work continues to have a similar process for nursing and therapy teams. Nursing workforce shortages have delayed the implementation. The appointment of a vascular network nursing and governance lead will provide the leadership required to progress this with the aim of having a process in place where communication is captured in one single place, anticipated by 31/01/2023.	Delay
	24079	Administrative and governance workforce analysis undertaken, identify gaps to support governance processes	Ms Jenny Farley, Vascular Network Director	31/10/2022	Identify the investment required to support effective documentation governance infrastructure	Delay

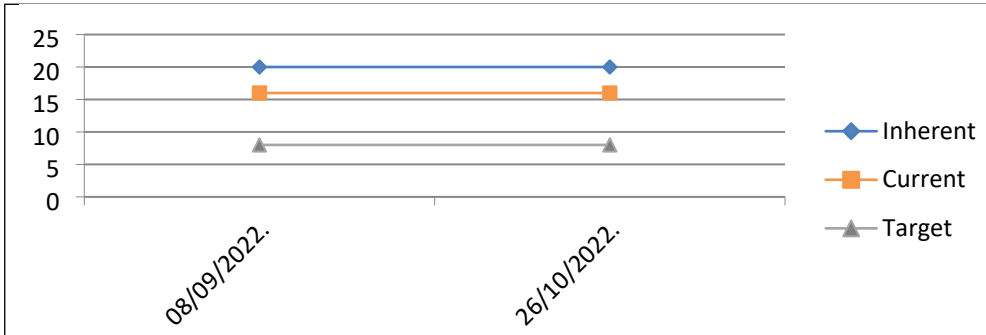
					October 2022 progress update – Intermediate Medium Term Plan funding will allow the appointment of a band 5 governance co-ordinator to support the management of governance processes. The funding has been approved for a National Vascular register inputter, which will support adequate reporting to the National register for Vascular procedures. Interim Network nursing and governance lead has been appointed to support implementation of all governance procedures and processes as well as service re-design of the current clinical governance pathways.	
	24080	Case note filing training to be given to Ward Teams	Miss Victoria Stafford, Ward Manager	30/11/2022	Will ensure correct filing processes for all patient records reducing the risks associated with poor documentation October 2022 progress update - There has been no permanent ward clerk who is responsible for filing in place, which has delayed the ability to	Delay

					provide training. Anticipated delay to the action due date.	

CRR22-32 (former CRR20-06)	**Director Lead:** Chief Digital And Information Officer	**Date Opened:** 08 September 2022
	Assuring Committee: Partnerships, People and population Health Committee	**Date Last Reviewed:** 26 October 2022
	Risk: Retention and Storage of Patient Records	**Date of Committee Review:** 08 November 2022
		Target Risk Date: 30 September 2024

There is a risk that patient information is not available when and where required, this may be caused by lack of suitable and adequate storage space, uncertain retention periods (Infected Blood Enquiry/Covid) and logistical challenges of sharing and maintaining standards of paper case records across the organisation.

This could lead to substandard care, patient/staff harm and inability to meet our legislative and Health and Safety responsibilities along with reputational damage and fiscal penalties.



	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 - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Digital, Data and Technology Strategy in place, with regular reporting to Partnerships, People and Population Health Committee. 2. Corporate and Health Records Management Policies and Procedures are in place pan-BCUHB, monitored by the Patient Records Group.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance

3. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records. 4. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group). 5. Standard Operating Procedure in place pan-BCUHB and off-site storage secured to manage the increased storage demands in response to the embargo on the destruction of patient records (in line with retention) due to the Infected Blood Inquiry. 6. New scanning and destruction provider Storetec in place, ISO 9001 accredited who are beginning to scan records directly into the CiTO records management system.	and Information Governance Committee. 3. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Lack of fit for purpose on site estate to hold physical records with no plans to back record convert all patient records. Health and Safety review ongoing to establish safe storage options, including off site storage. 2. Lack of central oversight of records sent out by other departments. Urgent meeting to support standardisation and consistency of processes. Reporting of compliance to Patient Records Group to be implemented. Meeting held with Concerns Team and revised process implemented to ensure standard centralised process followed. 3. Local site improvement plans being developed in a silo manner without standardised approach across the Health Board. Health Records representation is now on improvement boards. 4. Lack of digital systems in place, CITO programme underway to implement an electronic document patient record and integration with National systems.

Progress since last submission
1. Controls in place reviewed and updated to ensure relevance with current status of the risk. 2. Gaps in controls reviewed and updated to ensure relevance with current risk position. 3. It is anticipated that a current score of 12 will be achieved by the 30 September 2023. 4. Action ID 24372, action transferred from risk CRR20-06, former action ID 12429. 5. Action ID 24374, action transferred from risk CRR20-06, former action ID 23746. 6. Action ID 24375, action transferred from risk CRR20-06, former action ID 23747. 7. Action ID 24376, action transferred from risk CRR20-06, former action ID 23749. 8. Action ID 24378, action transferred from risk CRR20-06, former action ID 23750.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

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	24372	Engage with the Estates Rationalisation Programme to secure the future of 'fit for purpose' file libraries for legacy paper records.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	31/01/2023	Formally action ID 12429 from risk CRR20-06. Mental Health Business case has been agreed, further discussion ongoing with Estates to secure current accommodation for patient records October 2022 progress update – New roof in Wrexham commenced 23/10/22. New floor in the Ablett unit now in place.	On track
	24374	A new all encompassing Patient Records Programme is established that pulls all streams of work under one overall governance arrangement.	Mrs Nia Aspinall, Head of Patient Records and	30/09/2024	Formally action ID23746 from risk CRR20-06. A programme in place that will support the mitigation of the risk	On track

			Digital Integration		October 2022 – Meeting 26/10/22 with Integrated Clinical services leads to discuss funding for a programme lead.	
	24375	The identification or recruitment of a Programme Manager (8a) established for the overall programme and ensure all three elements are scoped and re-costed.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	30/09/2024	Formally action ID 23747 from risk CRR20-06 The action will provide support in the mitigation of the risk. October 2022 – Meeting 26/10/22 with Integrated Clinical services leads to discuss funding for a programme lead.	On track
	24376	The DHR Programme is re-scoped into an EDRMS.	Mrs Nia Aspinall, Head of Patient Records and Digital Integration	30/09/2024	Formally action ID 23749 from risk CRR20-06. To focus on addressing the more immediate patient records management challenges facing the Health Board utilising the proven capabilities of the CITO product.	On track
	24378	Immediate review of the patient record policies, standard operating procedures and the associated delivery of	Mrs Nia Aspinall, Head of Patient Records and	30/09/2024	Formally action ID 23750 from risk CRR20-06. Ensure all policies are up to date and relevant with new	On track

		training and awareness to improve integrity.	Digital Integration		processes and raising awareness amongst staff.	
	24379	Review all files and utilise off site storage for files due for destruction.	Nia Harrison, Health Records Manager	31/03/2023	Will increase the storage capacity onsite. Ongoing – Identification of files being undertaken to be sent off site to Storetec for scanning	On track
	24380	Risk assess all file storage locations including racking at main sites - To be undertaken by Health and Safety and Fire Safety Officers.	Nia Harrison, Health Records Manager	30/03/2023	Provide safe and secure location for patient files and staff working environment.	On track
	24381	Meeting to be set up with estate management to discuss current issues i.e. – Wrexham roof, YGC porta cabins and temporary locations.	Mrs Jane Carney, Health Records Site Manager	31/12/2022	Work towards providing a safe working environment for staff and the protection of Patient records. October 2022 progress update - further discussion ongoing with Estates to secure current accommodation for patient records. New roof in Wrexham commenced 23/10/22. New floor in the Ablett unit now in place.	On track
	24382	Project to be set up to look at back record conversion of Patient records via scanning technology.	Mrs Nia Aspinall, Head of Patient Records and	30/09/2024	Provide digitalised copies of records and reduce facility requirements of patient records.	On track

			Digital Integration		Ability to meet our legislative and Health and Safety responsibilities along with reputational damage and reduce any fiscal penalties.	

CRR23-33 (former CRR20-06)	**Director Lead:** Chief Digital Information Officer **Assuring Committee:** Partnerships, People and Population Health Committee **Risk:** Lack of access to clinical and other patient data **lated following approval**		**Date Opened:** 28 October 2022 **Date Last Reviewed:** 28 October 2022 **Date of Committee Review:**		
				Impact	Likelihood	Score
		Inherent Risk Rating		4	5	20
		Current Risk Rating		4	4	16
		Target Risk Score	Revised Risk	4	2	8
		Risk Appetite	**Target Risk Date:** 01 April 2025	low level		1-8

There is a risk that Patient Information is not available when and where required, this is due to a lack of access to a single clinical data repository for patient records, unconnected separate clinical systems and local data repositories.

This could result in substandard care, patient/staff harm and inability to meet our legislative and Health and Safety responsibilities along with reputational damage and fiscal penalties.

Controls in place	Assurances
1. Digital, Data and Technology Strategy in place to set the direction and vision for digital integration, with regular reporting to, Partnerships, People and Population Health Committee. 2. Corporate and Health Records Management policies and procedures are in place pan-BCUHB, monitored by the Patient Records Group for the handling and management of records. 3. Key Performance Indicators monitored at BCUHB Patient Records Group (reported into the Information Governance Group) with assurance provided to the Performance, Finance and Information Governance Committee.	1. Chairs reports from Patient Record Group presented to Information Governance Group. 2. Chairs assurance report from Information Governance Group presented to Performance, Finance and Information Governance Committee. 3. Internal Audit Annual Information Governance Compliance Audit.

4. iFIT Radio-Frequency Identification (RFID) casenote tracking software and asset register in place at acute sites to govern the management and movement of patient records. 5. Paper file identified as the Master Copy of the full record. 6. Access to current clinical systems to print clinical information ready to store in the Master File. 7. Information Governance Toolkit embedded with operational group oversight and monitoring. 8. Contract in place with third party supplier who are ISO accredited to scan directly into CiTO and destroy clinical paper records confidentially.	4. Information Commissioners Office Audit.

Gaps in Controls/mitigations
1. Lack of oversight held outside of the central patient records function, for example Mental Health and Paediatrics. 2. Lack of integrated systems with a single source of truth. CiTO Programme underway to implement an electronic document patient records. 3. Single Paper Record repository. Records are held across various sites as limited transportation available which leads to delays in record availability. Current weekly collections in place, but this is not sustainable for the future.

Progress since last submission
This risk is linked to CRR22-32 – Retention and Storage of Patient Records.

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use of resources (key enabler) Transformation for improvement (key enabler)	BAF21-16 BAF21-21

Risk Response Plan Actions being implemented to achieve target risk score	Action ID	Action	Action Lead/ Owner	Due date	State how action will support risk mitigation and reduce score	RAG Status
	24326	Establish the cost and resources requirements to back scan all live records.	Nia Aspinall, Head of Patient Records and Digital Integration	31/10/2023	The action will support a reduction in the risk score as records will be available electronically pan BCUHB.	On track
	24327	Following completion of the Baseline assessment of the location of all records, a review and recommendations will be developed and presented Partnerships, People and Population Health Committee.	Nia Aspinall, Head of Patient Records and Digital Integration	01/04/2024	The action will identify all locations of record storage, with the intention to provide a greater level of assurance with standards and compliance.	On track
	24328	Undertake a review of national systems to ensure these can be integrated in the Health Board's CiTO System.	Angharad Wiggin, DHR Programme Manager	01/04/2025	The action will provide single access to all patient data and support the achievement of the target risk score.	On track

Appendix 2 – Newly Escalated Risks

CRR23-34	**Director Lead:** Executive Director of Public Health	**Date Opened:** 28 June 2017
	Assuring Committee: Partnerships, People and Population Health Committee	**Date Last Reviewed:** 31 October 2022
	Risk: There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.	**Date of Committee Review:** New Risk
		Target Risk Date: 31 March 2024
There is a risk that residents in North Wales may be unable to quit smoking. This may be caused by their current smoking behaviours including use of vapes and illicit tobacco, income levels, living in socio-economically deprived areas, have a mental health condition or disability, or are from ethnic backgrounds and/or from the LGBTQ+ community. This may result in lack of confidence and/or capacity to engage with Help Me Quit Services. This may result in premature mortality and disease including cancers, respiratory diseases and cardio vascular disease, including strokes, heart attacks and dementia. This may impact on the Board's ability to achieve its national performance target. This will impact on the Board's ability to comply with the Smoke Free Regulations 2020.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	3	5	15
	Current Risk Rating	3	5	15
	Target Risk Score	3	4	12
	Risk Appetite	low level		1-8
	Movement in Current Risk Rating Since last presented to the Board in - New Risk not presented to Board	New Risk		

Controls in place	Assurances
1. Continuation of the HMQ for Baby Service with additional investment from Prevention and Early Years funding to support the development and pilot of an Incentivisation Scheme in one area. 2. Continuation of the HMQ in Hospital Service with additional investment from WG Prevention and Early Years funding to support the further development of this service in line with NHS Performance Framework 22-23 to support both staff and patients. 3. Investment from the WG Prevention and Early Years funding to provide support for patients with mental health conditions to support introduction of Smoke Free Regulations. 4. Pharmacy Level 3 Services supported by Prevention and Early Years funding. 6. Insight work to understand barriers identified by priority groups in accessing HMQ Services. 7. HMQ Communications Plan to include a focus on promotion of new service developments and informed by engagement with priority groups with targeted social media to encourage take up of Services. 8. Nicotine Replacement Therapy for staff insight report. 9. BCUHB's Smoke Free Regulations response to include support for staff, patient documentation, no smoking policy, signage, mental health services provision, compliance support and interface with Local Authorities. 10. Business Case for Hospital Compliance Officers (Smoke Free Environment Officers). 11. 'No Ifs No Butts' campaign with partners across the region. 12. De-normalisation actions with partners across the region.	1. Risk is regularly reviewed at the Senior Manager`s meetings and at their local governance meeting. 2. The Public Health Performance & Risk Management Group meets monthly to consider current risks. 3. Escalation from Public Health Performance & Risk Management Group is to the Public Health Senior Leadership Team, with review by the Population Health Executive Delivery Group also. 4. The risk is linked to Corporate Risk register entry CRR22-20 in respect of wider determinants. 5. Prevention and Early Years National Programme - nationally funded. 6. Reporting progress to National teams (Public Health Wales/Welsh Government/Regional Partnership Board). 7. Work plans are reflected in Health Board Annual Operating Plan, Living Healthier staying well strategy and draft Integrated Medium Term Plan (22-25).

Gaps in Controls/mitigations
1. The current provision does not meet the scale required to address current or forecast North Wales population requirements.

2. It is acknowledged that this is a long term risk which cannot be mitigated within 1-3 years based on evidence and research. As a Health Board we will work with partners to implement the approaches which support the strongest evidence base for success.
3. Provision currently through National funding, with funding identified for 2 years, cost pressures for the health board if the national funding were withdrawn.
4. Services are not based onsite at all main hospitals.
5. There are difficulties attracting to vacant posts due to fixed term nature - funding is not recurrent.

Progress since last submission
A small BCUHB group has been established to update the policy in line with smoke free legislation relating to mental health and to complete an updated and more comprehensive EQIA alongside this policy. Occupational health are currently leading this supported by BCUHB colleagues. It is anticipated that this work will be completed by end November, following this the reports will then be submitted to relevant BCUHB groups/committees for information.

Links to	
Strategic Priorities	**Principal Risks**
Strengthen our wellbeing focus	BAF21-02

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	22820	Communication - social media HMQ	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Encourage smokers to access services and quit	On track

	22823	HMQ Services Strengthening the Service	Mrs Gwyneth Page, Public Health Assurance & Development Manager	30/12/2022	Encourage smokers to access services and quit	On track
	22824	Communication - Partnership Plan	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Encourage smokers to access services and quit	On track
	22825	HMQ Services - Accommodation of staff	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/12/2022	Encourage smokers to access services and quit	On track
	24229	Maternity incentive pilot	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	This will encourage people to attempt quit, accept support and stay quit. Reduction in pregnant smokers in line with priorities in the tobacco control action plan.	On track
	24230	Primary Care Project (EAST Managed Practices)	Mrs Gwyneth Page, Public Health Assurance & Development Manager	31/03/2023	Engaging with smokers through local GP practice to encourage interaction with service and quit attempts.	On track

CRR23-35	**Director Lead:** Executive Director of Finance and Performance	**Date Opened:** 19.11.2018
	Assuring Committee: Quality, Safety and Experience Committee	**Date Last Reviewed:** 02.11.2022
	Risk: Electrical and Mechanical Infrastructure on the Wrexham Maelor Site	**Date of Committee Review:** New Risk
		Target Risk Date: 31.03.2027
There is a risk of system failure in regard to the Infrastructure on the Wrexham Maelor site which is becoming increasingly obselete due to age and condition. The impact could result in an immediate and unplanned loss of clinical services.		

To be populated following approval		Impact	Likelihood	Score
	Inherent Risk Rating	4	5	20
	Current Risk Rating	4	4	16
	Target Risk Score	3	2	6
	Risk Appetite	Select low, moderate or high level		1-8
	Movement in Current Risk Rating Since last presented to the Board in – New Risk	New Risk		

Controls in place	**Assurances**
1. On Call Estates Officers and site shift staff available to attend in the case of a failure or outage. Specialist Electrical and Mechanical Engineering Contractors on-call to attend site 2. Specialist Imprest stock held in stores. 3. Bi monthly meeting of Business Continuity Team which includes representation of all stakeholders impacted by this risk. 4. The BCU Planning Team (Chaired by the Hospital Director) have developed a Business Continuity Plan for essential mitigation of electrical infrastructure	1. Risk discussed at Estates Divisional meeting - Bi-monthly. Discussed at the East Site and IHC Risk Management Groups. 2. Authorised engineers (auditors) that assess compliance with current HTMS.

associated site risks and also includes those services which would be affected and need to relocate.	

Gaps in Controls/mitigations
Redevelopment Programme planning although recommenced is not finalised.

Progress since last submission
New Risk

Links to	
Strategic Priorities	**Principal Risks**
Making effective and sustainable use 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	21570	Business Continuity Planning	Mr Rod Taylor, Director Of Estates	01.04.2022	The aim of this approach is to provide Corporate assurance that a sequence of progressive management actions are in place to mitigate and react to site developments in order to provide near continuous support to YMW based services.	Completed

	21488	Internal Gateway Review -YWM PBC	Mr Rod Taylor, Director Of Estates	31.03.2023	This approach will provide assurance review to confirm if sufficient resource has been made available and how the risk will be managed until all issues are resolved.	Completed
	21571	YWM Continuity Programme Phase One	Mr Rod Taylor, Director Of Estates	31.03.2024	This will provide clarity on the deliverables, timelines and identify any unresourced areas.	On track
	23751	YWM Redevelopment Programme	Mr Ian Donnelly, Ihcd Operations East	31.03.2024	This will provide assurance that all elements of the PBC have been implemented and associated risk will therefore have been effectively managed and reduced.	On track
	24340	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace full sections of cable between substations in their entirety therefore reducing the amount of joints and as such improving resilience. In order to mitigate the risks the following replacements are proposed with 11kv rated armoured cable:	On track
	24341	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	To provide the level of resilience security and switching control required it is proposed that a new substation is constructed which can accommodate a 6-panel distribution panel, this is also to accommodate a separate switchgear from the DNO which	On track

					will controlled by the Health Board.	
	24342	Phase 1 Continuity Scope of Works - Utilities and Electrical Infrastructure (Workstream 3)	Mr Rod Taylor, Director Of Estates	31.03.2024	It is proposed that to provide greater resilience for this element that the substation is fitted with 2 No. ring main units and 2 No. 1,000 KVA transformers replacing the currently defective equipment.	On track
	24343	Phase 1 Continuity Scope of Works - Heating Systems in EMS Part of YWM Site	Mr Rod Taylor, Director Of Estates	31.03.2024	The risks with the heating systems will be mitigated by: Retaining pipework where there is a 2-pipe system and replacing areas served by 1 pipe systems – to increase the efficiency of the system. Installing separate heating systems for each of the outbuildings connected to the central boiler house, such that each building is self-sufficient – removing a single point of failure to the outbuildings. Installation of injection circuit stations at the head of each department – to provide greater control and aid commissioning. Installation of above ground distribution pipework – to allow maintenance and reduce any down times. Installation of instantaneous point of use water heaters to hand basins and sinks - removing the	On track

					single point of failure to the outbuildings.	
	24344	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 1)	Mr Rod Taylor, Director Of Estates	31.03.2024	The installation of 9 new area valve service units and new distribution pipework at a high level both externally and within the buildings for ease of access. NIST (Non-interchangeable screw threads) Lockable Line Valves will be provided where applicable so to minimise disruption to the Hospital should any future works to the system be necessary. The pipe run design has been sized at 35mm diameter to provide capacity for the system to work in pandemic conditions.	On track
	24345	Phase 1 Continuity Scope of Works - Medical Gas Supplies and Distribution Pipework (MGPS) (Workstream 2)	Mr Rod Taylor, Director Of Estates	31.03.2024	Installation of new vacuum plant to plant rooms 1.4 and 8a with associated pipework to run in areas which allow for ease of maintenance. This also allows for N+1 resilience and an overall capacity of 6,505L/min.	On track
	24346	Phase 1 Continuity Scope of Works - Medical Gas Supplies	Mr Rod Taylor,	31.03.2024	Installation of new multiplex medical air plant complete with safety valves and integral	On track

		and Distribution Pipework (MGPS) (Workstream 3)	Director Of Estates		controls. To service the increased capacity required of 6,800L/min and providing N+1 resilience.	
	24347	Phase 1 Continuity Scope of Works - Fire Detection Upgrade L1 and Fire Alarm Panels	Mr Rod Taylor, Director Of Estates	31.03.2024	The renewal of previously installed panels, including loop isolators which have become obsolete and the installation of a new separate network. A new network loop will be installed across the whole site excluding the residential facilities located within the north site.	On track
	24348	Phase 1 Continuity Scope of Works - Nurse Call including Emergency and Panic Alarms	Mr Rod Taylor, Director Of Estates	31.03.2024	To replace the Nurse call and Panic Alarms to all wards within the YMW site.	On track
	24349	Phase 1 Continuity Scope of Works - Heating Calorifiers and Roofing Works	Mr Rod Taylor, Director Of Estates	31.03.2026	To improve obsolete systems associated with Hot Water generation and distribution by upgrading existing Hot Water Calorifiers. Roofing refurbishment will take place to EMS Flat Roof areas and valleys.	On track
	24350	Phase 1 Continuity Scope of Works - Critical Ventilation Systems	Mr Rod Taylor, Director Of Estates	31.03.2027	Critical Ventilation Systems and plant replacement for Theatres 1 to 8 including upgrading the Main Kitchen Ventilation system.	On track

Appendix 3 - 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			
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		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
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.	Deputy Chief Executive Officer/Executive Director of Integrated Clinical Services	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
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

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
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.	De-escalated, risk being managed at Tier 2		
CRR22-26	Risk of significant patient harm as a consequence of sustainability of the acute vascular service	De-escalated, risk being managed at Tier 2		
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
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		

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
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		
CRR22-32 (Formally CRR20-06)	Retention and Storage of Patient Records	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-33 (Formally CRR20-06)	Risk of Lack of access to clinical and other patient data	Chief Digital and Information Officer	Partnerships, People and Population Health	16
CRR23-34	There is a risk that residents in North Wales will be unable to quit smoking due to wider influences and determinants.	Executive Director of Public Health	Partnerships, People and Population Health	15
CRR23-35	Electrical and Mechanical Infrastructure on the Wrexham Maelor Site.	Executive Director of Finance	Quality, Safety and Experience	16
CRR23-36	Cost of Living Impact on Staff and Patients - the risk associated with the impact of the increased cost of living on Staff and Patients and how that translates to the quality of Patient Care that BCUHB delivers	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	
CRR23-37	Targeted Intervention - risk that the Targeted Intervention Programme may not meet its targets and this would lead to a negative impact on the quality of Patient Care	Deputy Chief Executive (Proposed)	Quality, Safety and Experience	
CRR23-38	Workforce - The need to consolidate existing workforce risks into an appropriate described risk/risks that reflect the pan BCUHB position for the provision of services to patients. Also, to note a	Executive Director of Workforce and Organisational Development (Proposed)	Partnerships, People and Population Health	

Reference	Title	Executive Lead	Committee Oversight	Current Risk Score
	separate workforce risk related to statutory and regulatory requirements of being an employer			
CRR23-39	Patient Flow - Impact on Access and Quality of Care	Executive Director of Nursing and Midwifery (Proposed)	Quality, Safety and Experience	

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.

Teitl adroddiad: **Report title:**	Policy review - MD01 – BCUHB - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) .
Adrodd i: **Report to:**	Quality, Safety and Experience (QSE) Committee
Dyddiad y Cyfarfod: **Date of Meeting:**	Friday, 20 January 2023
Crynodeb Gweithredol: **Executive Summary:**	This paper advises the QSE Committee that in accordance with OBS1 - Policy for the Management of Health Board Wide Policies, Procedures and other Written Control Documents, MD01 - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) has undertaken a 3 year review. As a result of the review, minor updates, amendments and improvements have been made to the document.
Argymhellion: **Recommendations:**	The Committee is asked to: 1) Note that minor amendments / updates / improvements have been made as follows (changes within the document highlighted in yellow): a. Key documents section update and cross referenced in the body of the document b. Some links have been refreshed c. Page 14 – reference to the requirement to consult with Attorney under LPA – new bullet point added d. Page 18 – updated to include reference to relevant guidance (Equality / Chaperone). e. Page 21 – footnote added for definition of 'child' f. Page 31 (training / competency assessment) –The original sentence mirrored the sentence in the deanery letter, but wording added g. Page 47 – text updated and noting that it is good practice for a physical copy to be retained within the patient health record h. Page 64 – reference to MHLD 0026 Policy for Admission, Receipt and Scrutiny of Statutory Documentation added i. Page 74 - reference to MHLD 0026 Policy for Admission, Receipt and Scrutiny of Statutory Documentation added j. Page 82 – text added. 2) Approve the reviewed MD01 - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) as reviewed.

Arweinydd Gweithredol: **Executive Lead:**	Dr Nick Lyons - Executive Medical Director			
Awdur yr Adroddiad: **Report Author:**	Dr Ben Thomas – Assistant Medical Director – Law and Ethics Manon Gwilym – Clinical Law and Ethics – Legal Advisor			
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):**	To improve the safety and quality of all services.			
Goblygiadau rheoleiddio a lleol: **Regulatory and legal implications:**	Doctors, Nurses and Allied Health Professionals must adhere to professional standards set out in GMC, NMC, HCPC and other regulatory guidance. The Welsh Government's revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) - sets out the legal framework for consent			

	and can be found on the NHS Wales Shares Services Partnership internet page. The Supreme Court ruling in Montgomery v Lanarkshire NHS Health Board, has fundamentally changed the legal framework for consent to examination and treatment, enshrining the concepts of **informed consent** and **material risk** in UK law (discussed in chapter 3 of he policy), bringing the law on consent in line with existing regulatory guidance. Healthcare staff in this Health Board must comply with the standards and procedures in this policy. The NHS Wales model policy is consistent with current GMC guidance.
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?**	Yes, as per BCUHB Policy on Policies and WP7 Procedure for Equality Impact Assessments (EqlA), the EqlA is appended to this report.
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?**	No, the assessment is that an SEIA is not required. This report / policy does not relate to a 'strategic decision'. The Policy is in line with the all Wales Model Consent Policy / relevant legal requirements.
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)**	Failure to adhere to MD01 – BCUHB - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) may result in clinical negligence claims.
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith **Financial implications as a result of implementing the recommendations**	We recognise the challenges of transforming the legal framework for consent into clinical practice, where capacity is often limited and the safe and efficient operation of clinical pathways is essential to prevent delays in treatment. Failure to adhere to MD01 – BCUHB - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) may result in claims and related costs.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	Seeking consent is not only a legal obligation but also a matter of common courtesy between healthcare staff and

Workforce implications as a result of implementing the recommendations	patients. Both the Health Board and healthcare staff may be liable to legal action if valid consent is not obtained.
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori **Feedback, response, and follow up summary following consultation**	Reviewed policy - MD01 – BCUHB - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) noted and approved via: 1) Uploaded to the BCUHB Draft Documents for Consultation page with accompanying pan BCUHB communications 2) Consent and Capacity Strategic Working Group –27/09/2022 3) Clinical Effectiveness Group – 14/11/2022.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) **Links to BAF risks:** (or links to the Corporate Risk Register)	Not applicable
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) **Reason for submission of report to confidential board (where relevant)**	Not applicable

Next Steps:

1) Place the reviewed MD01 - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) onto the Policies, Procedures and other key documents page
2) Raise awareness of the reviewed MD01 - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy) via the BCUHB weekly bulletin
3) Increase engagement with relevant training on decision making and consent. NHS Wales e-learning package on 'Decision Making and Consent' now available on ESR
4) Continue BCUHB Peer Review of Consent processes within the Tier 2 audit programme
5) Specialties to promote the continued use of specified procedure specific patient information leaflets produced by EIDO or recognised national professional body as outlined in the WRP management alert
6) Undertake a review of all procedure specific leaflets in circulation within the Health Board against the WRP management alert.

Rhestr o Atodiadau:

List of Appendices:

1) MD01 - Policy On Consent To Examination Or Treatment (Based On The All Wales Model Policy)
2) MD01 - EQIA

Version: 3.3

Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board

MD01

Draft - POLICY ON CONSENT TO EXAMINATION OR TREATMENT (Based on the All Wales Model Policy)

Date to be reviewed:	October 2022	**No of pages:**	91
Author(s):	All Wales Consent to Treatment Group Manon Gwilym – Clinical Law and Ethics Legal Advisor Dr Ben Thomas - Assistant Medical Director – Law and Ethics		
Responsible Dept / Director:	Executive Medical Director / Office of the Medical Director		
Approved by:	Consent and Capacity Strategic Working Group–27/09/2022 Clinical Effectiveness Group – 14/11/2022 Quality, Safety & Experience Committee – xx/xx/xx		
Date approved:	Xx/xx/xx		
Date activated (live):	October 2010		

Documents to be read alongside this policy:

Key Document - Welsh Government – Welsh Health Circular 2017/036: Guide to Consent for Examination or Treatment.

- Policies/ Guidance relating to - Mental Capacity Act 2005; MD21 – Guidance – Production of Informed Procedure Specific Consent Forms, Standard Operating Procedure, MORT/0064 – Consent (post mortem). All Wales DNACPR Policy; Research Standard Operating Procedure - TM01 and TM08; Governance; Confidentiality; Spiritual Care, Patient Identification Standard Operating Procedure, PTH/TR/601 - Refusal Of Blood And Blood Components Policy, Human Tissue Act 2004; Human Rights Act 1998, Safeguarding; Mental Capacity Act 2005 – Code of Practice, Deprivation of Liberty Safeguards (DoLS) – Code of Practice, Mental Health Act 1983 – Code of Practice, Human Fertilisation and Embryology Act 1990, Abortion Act 1967, SCH017– Covert Administration of Medicines, MHLD – 0026 - Policy for: Admission, Receipt and Scrutiny of Statutory Documentation, MHLD 0047 – Restraint Guidelines, Department of Health, Human Tissue Authority, Code of Practice B - 2017: Post Mortem Examination, National Institute for Health and Clinical Excellence Guidance, Human Transplantation (Wales) Act 2013 and its Code of Practice, HR1 Health Records Management Procedure (Including Retention and Destruction Schedule), IG17 Information Governance Procedure for the Non-Clinical Photography, Video / Audio Recordings of Patients or Staff. ISU02 Policy – Written Information for Patients. General Medical Council Guidance, Royal College of Surgeons Guidance, UK Blood Transfusion and Tissue Transplantation Services Guidance, Joint United Kingdom (UK) Transfusion and Tissue Transplantation Services Professional Advisory Committee Guidance, Joint Committee on Medical Genetics Guidance; Royal College of Physicians Guidance, BMA Guidance, Welsh Language Standards, Welsh Governments' Strategic Framework for Welsh Language Services in Health, Social Services and Social Care 'More than just words'; Policy PTH/HIS/0045; IG13 Confidentiality code of conduct and IG16 Guidance for staff on disclosing personal data.

Review	**Purpose of Issue/Description of current changes:** Policy Review – minor updates to the key documents section / cross reference in the body of the document and updating links.

Date EqIA completed:	May 2010
First operational:	October 2010

Previously reviewed:	June 2014	February 2016	October 2021	August 2022	
Changes made yes/no:	Yes	Yes	Yes	Yes	

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

Contents

Glossary

AC	**Approved clinician (Supplementary guidance only)**
ADRT	**Advance Decision to Refuse Treatment**
BMA	**BMA – British Medical Association**
BNF	**British National Formulary (Supplementary guidance only)**
CAD	**Court Appointed Deputy**
CANH	**Clinically Assisted Nutrition and Hydration**
Cop	**Court of Protection**
CTO	**Community Treatment Order (Supplementary guidance only)**
DBD	**Donation after brainstem death**
DCD	**Donation after circulatory death**
DNA	**Deoxy-ribo Nucleic Acid**
DNACPR	**Do Not Attempt Cardiopulmonary Resuscitation**
ECT	**Electroconvulsive Therapy**
EPO	**Emergency Protection Order**
GMC	**General Medical Council**
HFEA 1990	**Human Fertilisation and Embryology Act 1990**
HFEA	**Human Fertilisation and Embryology Authority**
HIW	**Healthcare Inspectorate Wales (Supplementary guidance only)**
HRA	**Human Rights Act 1998**
HTA 2004	**Human Tissue Act 2004**
HTA	**Human Tissue Authority**
HTA 2013	**Human Transplantation (Wales) Act 2013**
IMCA	**Independent Mental Capacity Advocate**
IMHA	**Independent Mental Health Advocate (Supplementary guidance only)**

ICSI	**Intracytoplasmic sperm injection**
IVF	***In vitro* fertilisation**
LPA	**Lasting Power of Attorney**
MCA	**Mental Capacity Act 2005**
MHA	**Mental Health Act 1983**
MCS	**Minimally Conscious State**
Montgomery	***Montgomery v Lanarkshire NHS Health Board***
OPG	**Office of the Public Guardian**
PPO	**Police Protection Order**
PDOC	**Prolonged Disorder of Consciousness**
PVS	**Persistent Vegetative State**
SCT	**Supervised Community Treatment (Supplementary guidance only)**
SOAD	**Second Opinion Doctor (Supplementary guidance only)**
WHC	**Welsh Health Circular**

Foreword

The Supreme Court ruling in *Montgomery v Lanarkshire Health Board* [2015] fundamentally changed the legal framework for consent to examination and treatment in the UK, focusing the consent process on the specific needs of the individual patient.

Existing best practice guidance from the General Medical Council (GMC) and other regulatory bodies has already highlighted the importance of individual autonomy and the active involvement of an informed patient in a shared decision-making process. The *Montgomery* judgement closed the gap between the legal and regulatory frameworks. The practical implications for clinical practice are clear, but so too is the legal framework.

The core part of this Policy provides general guidance on consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England. Guidance is also incorporated for decision-making when patients temporarily or permanently lack capacity. Supplementary guidance is provided for specific scenarios that may be encountered in Obstetrics and Gynaecology or Mental Health settings.

We recognise that this is a lengthy policy document, but wanted to provide a detailed point of reference for healthcare professionals covering different situations they may encounter in their clinical practice. This policy also refers to the recently updated 'Guide to Consent for Examination or Treatment', produced by the Welsh Assembly Government, which provides a detailed overview of the current legal framework.

Executive summary

What is consent?

- Consent is a patient's ongoing agreement to treatment or care
- It is a process – not a one-off event
- For consent to be valid –
    - the patient must have the mental capacity to make the relevant decision about their treatment or care
    - consent must be given voluntarily
    - he or she must be properly informed about the proposed intervention
- Compliance, where a patient is not able to make an informed decision, is not "consent"

What information should be provided?

Patients must be provided with all the information they require, in a format and language they can understand, so that they can make an informed decision about what treatment, if any, they want to receive. The following should be discussed with the patient:

- All reasonable treatment options including the option of no treatment
- All of the intended benefits and material risks
- Any requirement to take and retain tissue samples, photographs etc.
- The presence of any trainees or students
- The use of any experimental techniques
- Any requests for further information or clarification should be met
- Outside an emergency setting, patients should be given adequate time to consider all of the relevant information

What is a material risk

The test of materiality is whether, in the circumstances of the particular case:

- a reasonable person in the patient's position would be likely to attach significance to the risk; or

- the clinician is, or should be, reasonably aware that the particular patient would be likely to attach significance to it

What are the exceptions to the duty to disclose all relevant information?

- Where the patient has made it clear that they do not want to know the risks involved; or
- Where treatment is required urgently, but the patient is unconscious or unable to make the decision for any reason (treatment is provided on the grounds of necessity); or
- Where advising the patient of the risks would be seriously detrimental to their health (this 'therapeutic exception' is limited and should not be abused)

When do healthcare professionals need to obtain consent?

- Before any kind of treatment or care is provided, if the patient has capacity to consent

Who is the right person to seek consent?

- The healthcare professional providing the intervention
- Seeking consent can be delegated to an appropriately trained colleague. Please refer to *section 5: Who is responsible for seeking consent*.
- If you have been asked to obtain consent but don't feel competent to do so, you must refuse

How does a patient give consent?

- Consent is given through an ongoing dialogue between the patient and healthcare professional
- Consent will normally be given verbally or in writing, but consent may also be implied in certain circumstances
- The consent form is a record of the patient's decision, along with the record of any related discussions in a patient's medical or nursing notes
- A signature on a consent form does not prove that valid consent has been obtained
- This consent policy explains when you should obtain written consent

Can children (aged under 16 years) give consent for themselves?

- Children under 16 years who are *Gillick*[1] competent can give consent
- Where a child is not *Gillick* competent, someone with parental responsibility must give consent on their behalf, unless the situation is an emergency and they cannot be contacted
- If a *Gillick* competent child consents to treatment, a parent **cannot** over-ride that consent
- If a *Gillick* competent child refuses necessary treatment, legal advice should be sought
- Not all parents have parental responsibility for their children (e.g. unmarried fathers do not automatically have such responsibility)
- If you doubt whether a patient has parental responsibility for a child, you must check

What about patients (aged 16 years and over) who lack capacity to give consent?

- Patients (aged 16 years and over) are presumed to have mental capacity unless demonstrated otherwise. A patient lacks capacity to make a specific decision if:
    - They have an impairment or disturbance that affects the way their mind or brain works; and
    - That impairment or disturbance causes them to be unable to make a specific decision at the time it needs to be made
- An assessment of a patient's capacity must be based upon their ability to make a specific decision at the time it needs to be made. A patient with an "impairment or disturbance" is unable to make a decision if they cannot do one or more of the following:
    - **Understand** the information relevant to the decision
    - **Retain** the information long enough to make a decision
    - **Use or weigh up** the information as part of a decision-making process
    - **Communicate the decision** – this could be by talking or using sign language and includes simple muscle movements such as blinking or squeezing a hand

[1] *Gillick v West Norfolk and Wisbech AHA [1985] UKHL 7 (17 October 1985)*

A patient is not to be treated as unable to make a decision unless all practicable steps to help the patient do so have been taken without success. A patient can only be said to be unable to communicate when all forms of communication have been explored.

- A person who has authority under a Health and Welfare Lasting Power of Attorney (LPA) or a Court Appointed Deputy (CAD) with appropriate authority can give consent when the patient lacks capacity

- Where the Health and Welfare LPA covers life sustaining treatment, the person who has authority under the LPA must be consulted where decisions are being made about Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders or other ceilings of treatment.

- In the absence of a person with authority under a Health and Welfare LPA or CAD, or a valid and applicable advance decision to refuse treatment, you must determine the patient's best interests in accordance with Mental Capacity Act 2005 (MCA)

- 'Best interests' includes past and present wishes, feelings, beliefs and values of the patient lacking capacity and any other factors which they would take into account if they were able to do so

- You must, where practical and reasonable, consult people who care for, or have an interest in the welfare of the patient, about the patient's wishes and beliefs

- Where there is nobody with whom you can consult, apart from paid staff, an Independent Mental Capacity Advocate (IMCA) must be instructed where decisions are needed about serious medical treatment (including DNACPR orders). The only exception to this duty occurs when an urgent decision is required e.g. to save the patient's life. IMCAs will not make a decision for the patient, but healthcare professionals have a legal duty to consider their views.

Commented [LR1]: I think there needs to be specific reference to the requirement to consult with the Attorney under LPA for a DNACPR as well as this paragraph only mentions the IMCA

Commented [BT(-R2]: LPA referenced in bullet point above. Also stated on DNACPR form.

What about refusal of treatment?

- Adults with capacity are entitled to refuse treatment or withdraw consent for any reason, at any time, no matter how unwise this may seem. The exception is where the treatment is for mental disorder and the patient is detained under the Mental Health Act 1983 (MHA)

- A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to the health of the fetus. If a woman in labour refuses treatment seek urgent legal advice

- If an *un-sedated* patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately and the event recorded in the notes

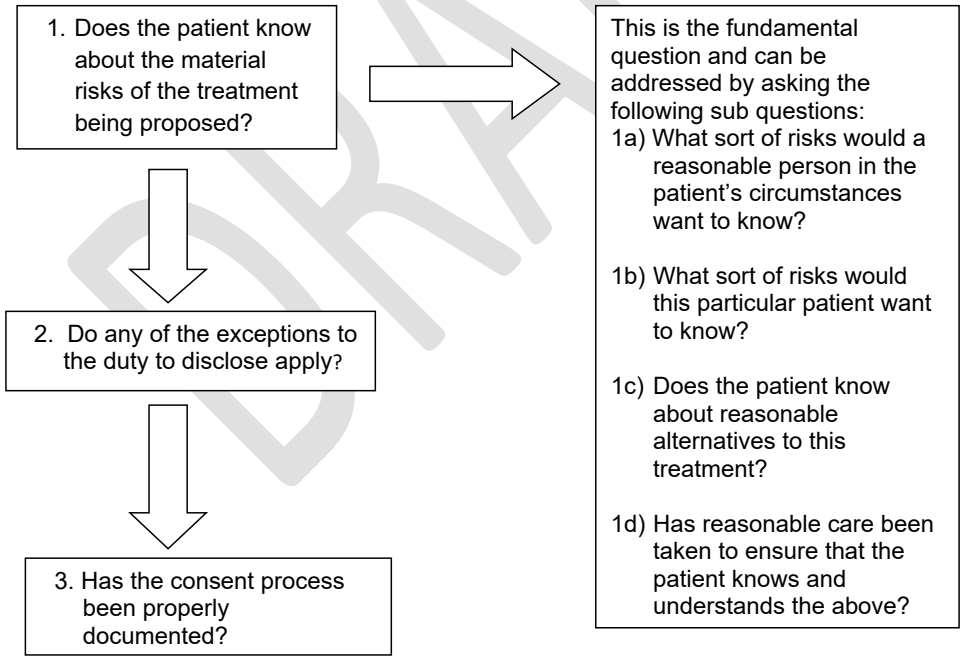
- If a patient lacks capacity but has clearly indicated in the past, while competent, that they would refuse treatment in specified circumstances (an advance decision), and those circumstances arise, you must abide by that decision if it is **valid** and **applicable**

- Advance decisions (made by patients with capacity aged 18 years or over) about life-sustaining treatment **must be** made in writing and contain a statement that the advance decision is to apply even if their life is at risk. The document must be signed by the patient (or by someone appointed by them), in the presence of a witness, who must also sign the document.

Informed Consent Flowchart

If a patient has capacity they are entitled to decide which, if any, of the available treatments to undergo and their consent must be obtained before treatment.

In order to obtain and document informed consent the three questions below, together with the sub-questions, should be addressed:



CORE POLICY

1. Introduction

About this policy

1. This Health Board recognises that people have a fundamental legal and ethical right to determine what happens to their own bodies and this is reflected in this policy. Valid consent to treatment is absolutely central in all forms of healthcare, from providing personal care to undertaking major surgery. Seeking consent is not only a legal obligation but also a matter of common courtesy between healthcare staff and patients. Both the Health Board and healthcare staff may be liable to legal action if valid consent is not obtained.

2. Doctors, Nurses and Allied Health Professionals must at all times follow professional standards as set out in GMC, NMC, HCPC and other regulatory guidance. The Welsh Government's revised Welsh Health Circular (WHC) 2017/036: Guide to Consent for Examination or Treatment (the Guide) - sets out the legal framework for consent and can be found on the NHS Wales Shared Services Partnership internet page. The Supreme Court ruling *in Montgomery v Lanarkshire NHS Health Board*, has fundamentally changed the legal framework for consent to examination and treatment, enshrining the concepts of **informed consent** and **material risk** in UK law (discussed later in chapter 3), bringing the law on consent in line with existing regulatory guidance. Healthcare staff in this Health Board should comply with the standards and procedures in this policy, which should be applied in conjunction with the principles set out in the Guide.

3. While this policy is primarily concerned with healthcare and refers to healthcare staff in all NHS settings, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

4. A patient may either be an adult or a child. Reference in this policy to an adult means a patient of 18 years or above and a child is a patient who is under the age of 16. Reference in this policy to a young person means a child aged 16 or 17 years.

What consent is – and isn't

5. Consent is a patient's ongoing agreement for healthcare staff to provide care or treatment. Before providing care or treatment, healthcare staff should be satisfied that the patient has given his or her **consent**. Consent will only be valid if:

- the patient has capacity to give consent
- it is given freely and not under duress
- the patient has been properly informed

6. Consent can be given in writing, verbally or even indicated non-verbally (for example by presenting an arm for a pulse to be taken). In all cases it is essential that an adequate record of the consent is maintained for future reference.

7. The context of consent can take many different forms, ranging from the active request by a patient for a particular treatment (which may or may not be appropriate or available) to the passive acceptance of advice from a healthcare professional. In some cases, the healthcare professional will suggest a particular form of treatment or investigation and after discussion the patient may agree to accept it. In others, there may be a number of ways of treating a condition, and the healthcare staff will help the patient to decide between the available options.

The relevant questions to consider

8. In seeking to obtain valid consent, healthcare staff should ask themselves a series of questions, as follows.

Is there reason to doubt the patient's capacity to give consent?

9. In determining whether an adult or young person lacks the mental capacity (either temporarily or permanently) to give or withhold consent, healthcare professionals must act in accordance with the MCA and the MCA Code of Practice. It is important to remember that nobody can give consent on behalf of an adult, unless they are an appointed attorney with authority under a Health and Welfare LPA or Court Appointed Deputy. A patient who lacks capacity can, however, be given treatment if it is in their best interests in accordance with the MCA, unless there is a valid and applicable advance decision refusing treatment (advance decisions are valid only for adult patients).

10. When treating patients who may lack capacity, healthcare professionals should give careful consideration to chapter 8 of this policy and the Guide, particularly the paragraphs set out below.

Is the consent given freely?

11. Pressure to agree to a particular treatment can be intentionally or unintentionally applied by family, friends or healthcare professionals. Professionals should be alert to this possibility, and where appropriate, arrange to review the patient on their own to establish that the decision is autonomous.

12. When patients are seen and treated in environments where involuntary detention may be an issue, such as prisons and mental health hospitals, there is a potential for treatment offers to be perceived coercively, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the patient makes a decision freely. Coercion should be distinguished from providing the patient with appropriate reassurance concerning their treatment, or pointing out the potential benefits of treatment for their health. However, threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent, or using such matters to induce the patient to give consent are not acceptable. Consent will not be valid in these circumstances.

Is the patient aware of all of the material risks and benefits of the proposed treatment and or any alternatives, including no treatment?

13. The healthcare professional must inform the patient about all the material risks, benefits and available alternatives, including no treatment. Some patients, especially those with chronic conditions, become very well informed about their illness and may actively request particular treatments. In many cases, 'seeking consent' is better described as 'joint decision-making': the patient and healthcare professional need to come to an agreement on the best way forward, based on the patient's values and preferences and the healthcare professional's clinical knowledge.

14. The informed person may either be the patient or someone with parental responsibility. Where a patient lacks capacity to give consent to the specified treatment, the decision should be made in the patient's best interests in accordance with MCA 2005. It is important that a person acting under a Health and Welfare LPA or a CAD for health and welfare decisions is also aware of all material risks, benefits and available alternatives, including no treatment.

Cultural issues

15. Cultural diversity issues should be actively considered whilst obtaining patient's consent. Members of some religious faiths, for example, are extremely modest in relation to exposure of parts of the body and may only consent to examination or treatment if it is undertaken by someone of the same sex. For further information, please refer to local policies and guidelines – Health Board's WP8 Equality, Diversity and Human Rights Policy and SA04 Best Practice Chaperone Guidance for Adults & Children.

Commented [LR3]: This should be amended to refer to the local policies and guidelines

Commented [BT(-R4]: Happy with change

16. If there is any doubt or uncertainty in relation to particular consent issues contact the Clinical Law and Ethics Advisors via: BCU.Consent@wales.nhs.uk. If they are unavailable and the matter is urgent, please contact the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk.
Out of hours, please contact Bronze on call via switchboard.

2. Documentation

17. Healthcare professionals must clearly document the information provided to a patient and any related discussions during the consent process. This may be recorded on a consent form (with further detail in the patient's medical notes as necessary) or within an entry in the patient's medical notes. (See chapter 3).

18. Where the signing of a consent form is not required, healthcare professionals must document the consent process followed within an entry in the patient's medical notes, including details of any information provided or related discussions.

Valid forms of consent

19. It will not usually be necessary to obtain a patient's written consent to routine and low-risk procedures, such as providing personal care or taking a blood sample. However, if you have any reason to believe that the consent may be disputed later or if the procedure is of particular concern to the patient (for example if they have declined, or become very distressed about, similar care in the past), it would be advisable to do so.

20. It is rarely a legal requirement to seek written consent[2], but it is good practice to do so if any of the following circumstances apply:

    - the treatment or procedure is complex, or involves significant risks (the term 'risk' is used throughout to refer to any adverse outcome, including those which some healthcare professionals would describe as 'side-effects' or 'complications');
    - the procedure involves general/regional anaesthesia or sedation;
    - providing clinical care is not the primary purpose of the procedure;
    - there may be significant consequences for the patient's employment or personal life;
    - the treatment is part of a project or programme of research approved by this Health Board (see chapter 17 of this policy).

21. If you are in doubt about whether a procedure requires written consent, then the safest course of action is to complete an appropriate consent form.

22. It is important to note that the place in which the treatment or procedure is to be carried out e.g. outpatients / theatre / clinic / in the patient's home, etc. should not affect the type of consent taken. The nature of the consent (i.e. written,

[2]The Mental Health Act 1983 and the Human Fertilisation and Embryology Act 1990 require written consent in certain circumstances

verbal or implied) should be appropriate to the procedure concerned.

23. Abbreviations should never be used on consent forms.

24. Completed forms should be kept with the patient's medical notes. Any changes to a form, made after the form has been signed by the patient, should be initialled and dated by both patient and the relevant healthcare professional.

25. A patient's signature on a consent form does not prove that valid consent has been provided. If a patient has made a decision on the basis of inadequate information, or has not had sufficient time to make a decision, consent may not be valid. Conversely, if a patient has given valid verbal consent, the fact that they have not signed a consent form does not mean that consent is not valid. Patients may withdraw consent after they have signed a form; it is not a binding contract.

Standard consent forms – Consent Forms 1 and 2

26. There are two versions of the standard consent form:

- **Consent Form 1** for adults, young people or *Gillick* competent children[3]:
- **Consent Form 2** for parental consent for a child under 16 who is not *Gillick* competent

27. The consent forms have been designed to allow the patient to be given a copy in either Welsh or English. It is essential that the original top copy, which is in English, is the one filed in the patient's medical notes. See appendix A.

Form for patients aged 16 years and over who are unable to consent for themselves – Form 4

28. The standard consent forms (**Consent Forms 1 and 2**) should never be used for adult patients and young people who are unable to consent for themselves. Where an adult patient or young person does not have the capacity to give or withhold consent to a significant intervention, this should be documented in **Form 4** - Treatment in best interests: form for patients aged 16 years and over who lack capacity to consent to examination and treatment. See appendix A.

29. Although Form 4 is referred to as a consent form, it should be noted that no-one, other than a person who has authority under a Health and Welfare LPA or a CAD for health and welfare decisions can give consent on behalf of an adult patient. If a person who has authority under a LPA or a CAD is giving consent, then they should sign the appropriate section of Form 4. A copy of Form 4 should be offered to this person.

30. Form 4 requires healthcare professionals to document why the patient lacks the

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[3] Please refer to paragraph 4, page 16, for the definition of a child / young person within this Policy. Please also see chapter 7, Treatment of Children and Young People.

capacity to make this particular healthcare decision, and why the proposed treatment would be in his or her best interests, in accordance with the Mental Capacity Act 2005. Where the patient's family and friends have been consulted about the patient's wishes and feelings (in order to inform the determination of what is in the patient's best interests), the details of this discussion must also be recorded on the form. For further information regarding patients who lack mental capacity to give or withhold consent, see chapter 8 of this policy. For more minor interventions, this information should be entered in the patient's medical notes

Patient information leaflet

31. Patients may find consent forms daunting or confusing and an explanatory leaflet "**About the consent form**" is available for patients with questions or concerns (Appendix E).

Availability of forms

32. Consent Forms 1 and 2 and Form 4 can be ordered via the Oracle system.

Procedure/condition specific consent forms

33. Procedure specific consent forms may offer advantages for clinical practice and service organisations, providing standardised information about significant risks, benefits and alternative treatment(s). Space must be provided on these forms so that any additional material risks, which are specific to individual patients, can be recorded. The forms should also meet Welsh language requirements in line with the Welsh Language Standards.

34. The Health Boards has clear guidance on the development of procedure specific consent forms which must be approved through appropriate governance arrangements. Please refer to MD21 – Guidance for the Production of Procedure Specific Consent Forms.

3. When should consent be sought?

35. Outside an urgent setting, it is good practice to seek the patient's consent to the proposed procedure well in advance, so that there is time to respond to questions and provide adequate information for the individual patient to make a fully informed decision. Seeking consent should be viewed as a process rather than a one off event, reflecting a dialogue between the individual patient and the healthcare professional. The provision of information and related discussion are components of the shared decision-making process.

36. This process may take place at one time, or over a series of meetings and discussions, depending on the seriousness and/or urgency of the situation. Healthcare professionals should take reasonable care to ensure that patients are made aware of all of the intended benefits, material risks and alternatives to the proposed treatment.

What is a "material risk"?

37. The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the healthcare professional is or should be reasonably aware that the particular patient would be likely to attach significance to it.

38. All clinical staff should have regard to the ruling in the case of *Montgomery v Lanarkshire Health Board*[4] given on 11th March 2015.

39. Following this Supreme Court ruling, healthcare professionals are reminded of their professional responsibility to take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments."

40. This standard of consent is similar to that required in GMC Guidance – Good Medical Practice 2013 – namely, work in partnership with patients. Listen to, and respond to their concerns and preferences. Give patients the information they want or need in a way they can understand. Respect patients' right to reach decisions with you about their treatment and care[5].

41. Healthcare professionals must be satisfied that:

- The patient knows and understands all the material risks of the proposed treatment;
- The patient is aware of all reasonable alternatives;

[4] https://www.supremecourt.uk/cases/docs/uksc-2013-0136-judgment.pdf
[5] Good medical practice - ethical guidance - GMC (gmc-uk.org)

- They have taken reasonable care to ensure that the patient understands all of the relevant information
- Valid exceptions to the duty to disclose apply.

42. The three exceptions to the duty to disclose are:

- The patient tells the healthcare professional that he or she prefers not to know the risks;
- The healthcare professional reasonably considers that telling the patient something would cause serious harm to the patient's health and wellbeing
- Consent is not required as the patient lacks capacity and urgent treatment is required.

43. The Informed Consent Flowchart set out at the beginning of this document provides a useful reference guide for staff on the practical implications of the *Montgomery* case and is also available online[6].

Single stage process

44. In many cases, it will be appropriate for a healthcare professional to initiate a procedure immediately after discussing it with the patient. For example, during an ongoing episode of care a physiotherapist may suggest a particular manipulative technique and explain how it might help the patient's condition and whether there are any significant risks. If the patient gives their consent, the procedure can go ahead immediately. Verbal consent will often be provided in this situation. This should be recorded in the patient's medical notes.

45. If a proposed procedure/treatment involves significant and important material risks for the patient concerned, it may be appropriate to seek written consent. Healthcare professionals should also consider whether the patient has had sufficient opportunity or time to process the information required for them to make the relevant decision.

Two or more stage process

46. In most cases where *written* consent is being sought, treatment options will generally be discussed well in advance of the actual procedure. This may be on just one occasion or it might be over a whole series of consultations with a number of different healthcare professionals. The consent process will therefore have at least two stages: the first being the provision of information, discussion of options and initial (verbal) decision, and the second being confirmation that

[6] http://howis.wales.nhs.uk/sitesplus/documents/861/Legal%20and%20Risk%20-%20Montgomery%20flowchart.pdf

the patient still wants to go ahead[7]. A careful record of the information provided and the related discussion with the patient should be detailed in the patient's medical notes. The consent form may be used as a means of recording the information stage(s), as well as the confirmation stage.

47. Patients receiving elective treatment or investigations for which written consent is appropriate should be familiar with the contents of their consent form before they arrive for the actual procedure, and should have received a copy of the consent form documenting the decision-making process (either in Welsh or English). They may be invited to sign the form, confirming that they wish treatment to go ahead, at any appropriate point before the procedure: in out-patients, at a pre-admission clinic, or when they arrive for treatment. However, if a form is signed before patients arrive for treatment, a member of the healthcare team (for example a nurse admitting the patient for an elective procedure) **must** check with the patient at this point whether they understand the procedure and the risks involved, whether they have any further questions or further concerns and whether their condition has changed. This is particularly important where:

- there has been a significant lapse of time between the form being signed and the procedure;
- new information becomes available regarding the proposed intervention (for example, new evidence of risks or new treatment options);
- the patient's condition has changed significantly in the intervening period;
- the patient's responsible clinician has changed since the form was signed.

48. Similarly, if a patient is returning on multiple occasions for a course of treatment, a member of the healthcare team must check with the patient on each occasion that they still consent to the procedure. This confirmation of consent should be recorded on the consent form, or, if insufficient space, in the patient's medical notes.

49. When confirming the patient's consent and understanding, it is advisable to use a form of words which requires more than a yes/no answer from the patient: for example, beginning with "tell me what you're expecting to happen", rather than "is everything all right?"

50. It should always be remembered that for consent to be valid, the patient must feel that it would have been possible for them to refuse, or change their mind. It will rarely be appropriate to ask a patient to sign a consent form after they have begun to be prepared for treatment (for example, by changing into a hospital gown), unless this is unavoidable because of the urgency of the patient's condition.

[7] https://www.rcseng.ac.uk/standards-and-research/standards-and-guidance/good-practice-guides/consent/

51. The patient's consent may be obtained by post, as this gives the patient time to read and reflect on the consent form and information provided. However, any person carrying out a procedure must ensure, at the earliest opportunity following admission, that the patient has understood the information and that they still give their consent. If the patient has queries or concerns he or she must be given time to consider any additional information. It is important to remember that, whether a patient does or does not have capacity to consent, no relative or carer can sign on his or her behalf (unless provided for in accordance with the MCA – see chapter 8 of this policy) and under parental responsibility: if the competent child or young person wishes the parent to take the decision for them.

52. Patients should not be given pre-operative sedation before being asked for their consent to proceed with treatment (although women in labour can consent to a caesarean birth section even if they have received sedation – see paragraph 274 of this policy). If a situation arises where a change to the consent form is required after the patient has received sedation, this should only be done if the doctor responsible for the patient's care is clearly able to demonstrate that the patient still has capacity to be involved in the decision to make the required change. This must be documented in the patient's medical notes. The outcome of the assessment, any changes made to the consent form and the reasons for the changes must also be clearly documented in the patient's medical notes it is found that the patient does not have capacity due to the administration of sedation, any changes to the consent form should be delayed until capacity is regained (i.e. the effects of the sedation have worn off). If the urgency of the situation is such that a delay in undertaking the procedure would lead to harm to the patient, any decision that is made about continuing has to be made in the best interests of the patient. Best interests decisions and the reasons for them should be documented in the patient's medical notes. Chapter 8 of this policy provides further guidance on assessing capacity and making best interest decisions.

Seeking consent for anaesthesia

53. Where an anaesthetist is involved in a patient's care, it is their responsibility (not that of a surgeon) to seek consent for anaesthesia, having discussed the benefits and significant or material risks with the patient. In an elective setting, it is not acceptable for the patient to receive no information about anaesthesia until their pre-operative visit from the anaesthetist: at such a late stage the patient may not be able to make a considered decision about whether or not to undergo anaesthesia. Patients should therefore either receive a general leaflet about anaesthesia in an outpatient setting, or have the opportunity to discuss anaesthesia in a pre-assessment clinic. The anaesthetist should ensure that the discussion with the patient and their consent is recorded in the anaesthetic record, the patient's medical notes or on the consent form. Where the healthcare professional providing the care is personally responsible for anaesthesia (e.g. where local anaesthesia or sedation is being used), then he or she will also be responsible for ensuring that the patient has given consent to that form of anaesthesia.

54. Where general anaesthesia or sedation is being provided as part of dental treatment, the General Dental Council currently holds dentists responsible for ensuring that the patient has been provided all the necessary information. In such cases, the anaesthetist and dentist will therefore share that responsibility.

Emergencies

55. Clearly in emergencies, the two stages (discussion of options and confirmation that the patient wishes to go ahead) may follow straight on from each other, and it may often be appropriate to use the patient's medical notes to document any discussion and the patient's consent, rather than using a form. The urgency of the patient's situation may limit the quantity of information that they can be given, but should not affect its quality and should still include benefits, significant and important (material) risks and alternatives relevant to the individual circumstances of the patient.

Treatment of children and young people

56. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law and consider carefully whether the child or young person is competent to give his or her consent to the treatment. Chapter 7 of this policy provides further information.

Withdrawal of consent

57. A patient with capacity is entitled to withdraw consent at any time. Where a patient does object during treatment, it is good practice for the healthcare professional, if at all possible, to stop the procedure, establish the patient's concerns, and explain the consequences of not completing the procedure. If the patient confirms that they do wish to withdraw consent, and there is no immediate risk to stopping the procedure, then the procedure should be terminated immediately.

58. The healthcare professional should try to establish whether at that time the patient has capacity to withdraw consent. This is particularly important if the patient has been given sedation. If a patient lacks capacity, it may be justified to continue in the patient's best interests in accordance with the MCA.

59. If a sedated patient or one who otherwise lacks mental capacity to consent begins to struggle or resists treatment either verbally or physically, it is the responsibility of the healthcare professional to act in the patient's best interests. If this event occurs at a crucial time, which will have an impact on a successful outcome, then it would be wise to pause, attempt to regain co-operation and complete, perhaps with additional sedation. If the situation deteriorates, is irretrievable, and patient safety is likely to become compromised, then termination of the procedure is recommended. This must be recorded in the patient's medical notes.

60. Issues relating to withdrawal of consent by patients being treated in accordance with sections 57, 58 or 58A of the Mental Health Act are discussed in chapter 18 of this policy.

4. Provision of Information

61. The provision of information is central to the consent process. Before patients can make an informed decision about their treatment, they need comprehensible information about their condition and any reasonable treatment options and their risks and benefits (including the risks/benefits of doing nothing). Patients also need to know the scope of the intended treatment and whether additional procedures are likely to be necessary, for example blood transfusion or the removal of particular tissue.

62. Patients will differ in how much information they want about a proposed treatment. Some patients will want as much detail as possible, including details of rare risks, while others will ask healthcare professionals to make decisions for them. In such circumstances, the healthcare professional should explain the importance of understanding the significant risks and benefits of a recommended treatment, and making an informed decision. The *presumption* must be that the patient wishes to be well informed about the material risks and benefits of the various treatment options. Where the patient makes clear (verbally or non-verbally) that they do not wish to be given this level of information, this should be documented and the patient may be asked to sign the record to confirm their decision. It must be made clear to the patient that they can change their mind and have more information at any time.

Has the patient received sufficient information?

63. To give valid consent the patient needs to be provided with sufficient information to understand in broad terms the nature and purpose of the procedure. Information about any significant and material risks and benefits of the proposed treatment and any alternative options should be provided, including the option of no treatment. Any misrepresentation of these elements will invalidate consent. Where relevant, information about anaesthesia must be given (see paragraph 53 above) as well as information about the procedure itself.

64. The information provided should be tailored to the individual patient.

65. The use of patient information leaflets can help healthcare professionals to provide patients with the information they need, in order to arrive at an informed decision. Wherever possible patients should be sent information prior to their appointment so that they have time to read and absorb it, and can consider what questions they would like to ask when they meet with the relevant healthcare professional. This will help to ensure that they fully understand the treatment being proposed and can make an informed decision regarding consent. However, the use of leaflets does not remove the healthcare professional's responsibility to provide a verbal explanation of often much the same information. In this context,

the use of patient information leaflets is considered to be an example of best practice. The use and provision of the patient information leaflet should be documented on the consent form or in the patient's health records. A copy of the patient information leaflet should be inserted into the patient's health record. If an EiDO information leaflet has been used, its name, number and date can be documented. All staff producing patient information leaflets are required to develop information in line with ISU02 – Guidance – Written Information for Patients.

66. Patient information in different formats and languages must be made available.

Communication Issues

67. A patient must not be assessed as lacking capacity to consent to the particular investigation, treatment or care merely because they have a limited ability to communicate. Care should be taken not to underestimate the ability of a patient to communicate, whatever their condition. Healthcare professionals should take all reasonable steps to facilitate communication with the patient, using communication aids as appropriate. Particular consideration should be given to the way in which information is presented to the patient. Drawings, diagrams and models may be useful for example. In emergency situations, taking these steps may not be possible, but good practice would be to record the reasons for this in the patient's medical notes.

68. Where appropriate, those who know the patient well, including their family, friends, carers or staff from professional or voluntary support services, may be able to advise on the best ways to communicate with the patient. Healthcare professionals are encouraged by this Health Board to follow:

- the Triangle of Care Best Practice Guidelines: https://www.england.nhs.uk/wp-content/uploads/2017/11/case-study-supporting-well-carers-included.pdf

- the Mental Capacity Act 2005 – Code of Practice https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

- the National Institute for Health and Care Excellence Guidance – Decision – Making and Mental Capacity https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917

Provision for Welsh speaking patients

69. The Welsh Language (Wales) Measure 2011 has given the Welsh language official status in Wales by placing Welsh Language Standards on organisations - Welsh Language Standards Document.pdf. The duties deriving from the standards mean that the Health Board and its staff should not treat the Welsh language less favourably than the English language. In line with the Welsh

Language Standards, the language preference of the patient must be offered, established, recorded, acted upon and relayed to others within the Health Board. Welsh speaking healthcare professionals should ideally obtain consent from patients whose preferred language is Welsh. If the relevant healthcare professional is not Welsh speaking, consent should be obtained with the support of Welsh speaking colleagues or simultaneous translation.

- More than just words (gov.wales)
- Mwy na Geiriau (llyw.cymru)

70. The All Wales consent forms provided with this policy (see chapter 2 of this policy) have been designed bilingually so that the patient can be given a copy in either English or Welsh. It is essential that the top copy, which is in English, is completed and added to the patient's medical notes. Availability of bilingual consent forms ensures that:

- Welsh and English versions of consent forms are equally accessible to patients;
- both the patient and healthcare professional are clear about what is being agreed to in circumstances where a non-Welsh speaking healthcare professional is dealing with a Welsh speaking patient; and
- the needs of mixed-language families, other mixed-language audiences and Welsh learners are met.

Provision for patients whose first language is not English or Welsh

71. This Health Board is committed to ensuring that patients whose first language is not English or Welsh receive the information they need and are able to communicate appropriately with healthcare staff. This includes British Sign Language (BSL). In order to safeguard the consent process, unless the healthcare professional is fluent in the patient's preferred language, an interpreter should always be used when seeking consent from the patient. It is not appropriate to use children or family members to interpret for patients who do not speak English.

- Please refer to the Wales Interpretation and Translation Service

Access to more detailed or specialist information

72. Patients may sometimes request more detailed information about their condition or a proposed treatment than that provided in general leaflets.

Access to healthcare professionals between formal appointments

73. After an appointment with a healthcare professional, patients will often think of further questions which they would like answered before making a decision. Where possible, it will be much quicker and easier for the patient to contact the

healthcare team by phone than to make another appointment or wait until the date of an elective procedure, by which time it is too late for the patient to reflect upon the information. Patients should be provided with appropriate contact details at the time of their appointment.

74. The provision of advice over the telephone needs to be undertaken by suitably qualified staff and must follow agreed guidelines, policies and procedures. Advice given must be evidence based and up to date. A record must be kept in the patient's medical notes. Where advice deviates from accepted guidance, the advice given must be clearly documented and the reasons for such deviation stated.

Open access clinics

75. Where patients access clinics directly, it should not be assumed that their presence at the clinic implies consent to particular treatment. You should ensure that they have the information they need to give their consent before proceeding with an investigation or treatment.

Consent and inpatients

76. Irrespective of whether the patient is an inpatient or outpatient, the process of seeking consent must be adhered to. Just because a patient is already in a hospital bed, consent for examination and treatment cannot be assumed. As stated previously, the patient needs to be provided with sufficient time and information to understand in broad terms the nature and purpose of the procedure.

5. Who is responsible for seeking consent?

77. The healthcare professional carrying out the procedure is ultimately responsible for ensuring that the patient has given valid consent for the proposed treatment or procedure. He or she will be held responsible in law if the validity of consent is subsequently challenged.

78. Where verbal or non-verbal consent is being sought at the point the procedure will be carried out, this will be done by the healthcare professional responsible. However, team work is a crucial part of the way the NHS operates and, where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent e.g. providing information about the treatment or procedure.

Competence of those seeking consent

79. Consent must be obtained by a healthcare professional who is competent either because they themselves carry out the procedure or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit. Inappropriate delegation (e.g., where the healthcare professional seeking consent has inadequate knowledge of the procedure) may mean that the consent is not valid.

80. It is a healthcare professional's own responsibility:

- to ensure that when they require colleagues to seek consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence.

81. If you feel that you are being pressurised to seek consent when you do not feel competent to do so, discuss with a senior manager.

82. The Wales Deanery and the Welsh Government have made it clear that F1 doctors can only take consent in specific clinical situations (clinical procedure) where they have undertaken formal training as set out in paragraph 79 above has been assessed. Healthcare professionals are responsible for knowing the limits of their own competence and should seek the advice of appropriate colleagues when necessary.

Commented [LR7]: Formal consent training or training in the specific clinical procedure?

Completing consent forms

83. The standard consent form provides space for a healthcare professional to provide information to patients and to sign confirming that they have done so. The healthcare professional providing the information must be competent to do so.

84. If the patient signs the form in advance of the procedure (for example in out-patients or at a pre-assessment clinic), a healthcare professional involved in their care on the day should sign 'Confirmation of Consent' section of the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer questions they cannot handle themselves.

Attendance by students and trainees (i.e. pre-registration clinicians from any discipline)

85. Where a student or trainee healthcare professional is undertaking examination or treatment of the patient where the procedure will further the patient's care – for example taking a blood sample for testing – then, assuming the student is appropriately trained in the procedure, the fact that it is carried out by a student does not alter the nature and purpose of the procedure. It is therefore not a legal requirement to tell the patient that the healthcare professional is a student, although it would always be good practice to do so and consent in the usual way will still be required.

86. In contrast, where a student proposes to conduct a physical examination which is not part of the patient's care, then it is essential to explain that the purpose of the examination is to further the student's training and to seek consent for that to take place. Verbal consent must be obtained and a record made in the patient's medical notes.

87. A patient's consent should be obtained when a student is going to be present during an examination or treatment purely as an observer. Patients have the right to refuse consent in these circumstances without any detrimental effect on their treatment. Written consent must be obtained if students or trainees are going to be present during examination or treatment using sedation or anaesthetic.

88. Patients must be informed that they have the right to refuse consent to being observed, attended to or examined by students without any detrimental effect on their treatment.

89. It is essential that appropriate supervision of students is carried out in all of the above situations and that, where consent is required, the supervisor is reassured that valid consent has been obtained.

Attendance by company representatives

90. On occasions when company representatives need to be present for a procedure/treatment (e.g. where equipment is being used for the first time and the representative is there to assist with its use), written consent from the patient must be obtained.

6. Adults with Capacity – Refusal of treatment

Right to refuse treatment

91. An adult patient who has capacity can refuse any treatment, except in certain circumstances governed by the Mental Health Act 1983 (see chapter 13 of this policy). The following paragraphs apply primarily to adults. In determining whether a patient has capacity to make this decision the MCA must be applied. See chapter 8 of this policy.

92. An adult with capacity may make a decision which is based on their religious belief (e.g. Jehovah's Witnesses) or value system. Even if it is perceived by others that the decision is unwise or irrational, the patient may still make that decision if he or she has capacity to do so and it is a voluntary and informed decision. Any attempt to treat that patient against his or her wishes could amount to a criminal offence. It is the right of an adult patient with capacity to refuse treatment even if that refusal might result in their death. However, in cases of doubt, healthcare professionals should always seek legal advice.

93. If, after discussion of possible treatment options, a patient refuses treatment, this fact should be clearly documented in their notes. If the patient has already signed a consent form, but then changes their mind, the healthcare professional (and where possible the patient) should note this on the 'Patient has withdrawn consent' section of the consent form.

94. Where a patient has refused a particular intervention, the healthcare professional must ensure that he or she continues to provide any other appropriate care to which they have consented. You should also ensure that the patient realises they are free to change their mind and accept treatment if they later wish to do so. Where delay may affect their treatment choices, they should be advised accordingly.

95. If a patient consents to a particular procedure but refuses certain aspects of the intervention, the healthcare professional must explain to the patient the possible consequences of their partial refusal. If the healthcare professional genuinely believes that the procedure cannot be safely carried out under the patient's stipulated conditions, he or she is not obliged to perform it. They must, however, continue to provide any other appropriate care. Where another healthcare professional believes that the treatment can be safely carried out under the conditions specified by the patient, he or she must on request be prepared to transfer the patient's care to that healthcare professional.

96. Whilst a patient has the right to refuse treatment this does not mean that they have the right to require a particular course of treatment.

Self harm and attempted suicide

97. Cases of self harm present a particular difficulty for healthcare professionals but the same law and guidance, as set out above, applies to treatment of these cases. Where the patient is able to communicate, an assessment of their mental capacity should be made as a matter of urgency.

98. If the patient is judged not to have capacity, decisions about their physical health treatment need to be made in accordance with the MCA (see chapter 8 of this policy). If treatment is required for their mental health, the MHA will apply. If a patient has attempted suicide and is unconscious, and there is insufficient time to undertake the usual best interests decision making process then he or she should be given emergency treatment unless the healthcare professional is satisfied that an advance decision to refuse treatment exists which is valid and applicable to the life-sustaining treatment in these circumstances.

99. Adult patients with capacity do have the right to refuse life-sustaining treatment, both at the time it is offered and in the future even if the healthcare professional believes that the patient's decision is unwise. If a patient with capacity has harmed themselves and refuses treatment, it may be appropriate to consider obtaining a psychiatric assessment. Unless the adult patient with capacity is detained under the Mental Health Act 1983 and the treatment is for, or a symptom of, a mental disorder, then their refusal must be respected although attempts should be made to encourage him or her to accept help and healthcare professionals should consult legal advisers.

Patients who refuse blood or blood components (e.g. Jehovah's Witnesses)

100. The same legal principles apply to any patient who refuses treatment whether they do so out of religious convictions or otherwise. No patient should be considered to be likely to refuse blood products merely on the basis of their religion. Every patient needs to be asked and informed individually.

Further information on Jehovah's Witness Patients

101. It is important to remember that not all Jehovah's witnesses refuse blood products. Most practising Jehovah's Witnesses who do, will carry with them a clear, signed and witnessed advance decision card prohibiting blood transfusions and releasing clinicians from any liability arising from this refusal. If an applicable and valid advance decision is produced, then this should be acted upon. If the patient does not have capacity and a valid and applicable advance decision cannot be produced, the clinical judgement of a doctor should take precedence over the opinion of relatives or associates.

102. Further information can be found at the following:

- Royal College of Surgeons (2016, as updated) Caring for patients who refuse blood: a guide to good practice for the surgical management of Jehovah's

Witnesses and other patients who decline transfusion.

- Association of Anaesthetists of Great Britain and Ireland, 2nd Edition, (2005) *Management of Anaesthesia for Jehovah's Witnesses*.
- Hospital Information Services for Jehovah's Witnesses (2005) *Care plan for women in labour refusing a blood transfusion*.
- UK Blood Transfusion and Tissue Transplantation Services (http://www.transfusionguidelines.org.uk/index.asp?Publication=BBT&Section=22&pageid=510 *Better Blood Transfusion Toolkit: Appropriate Use of Blood: Pre-operative Assessment – Jehovah's Witnesses*.
- Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee chapter 12: Management of patients who do not accept transfusion

103. Further information or advice on the clinical management of this group of patients can be obtained from:

- A Consultant Haematologist within the Health Board
- PTH/TR/601 - Refusal Of Blood And Blood Components Policy
- The local Hospital Liaison Committee for Jehovah's Witnesses.

7. Treatment of children and young people

104. When treating or caring for children and young people, healthcare professionals should take account of chapter 5 of the Guide.

Children or young people with capacity to consent to treatment

105. When treating children and young people, healthcare professionals should take particular care to ensure that they are familiar with the relevant law.

106. Careful consideration should be given to whether the child is competent to give his or her consent to the specified treatment. A child under the age of 16, who has sufficient maturity and intelligence to be capable of understanding the treatment and making a decision based on the information provided (*Gillick* competent) will have capacity to consent to treatment and care. If a competent child consents to treatment a parent cannot over-ride that consent. As with adults, consent will only be valid if it is given voluntarily by an appropriately informed patient who has capacity to consent to the particular treatment.

107. Young people aged 16 or 17 with capacity are assumed in law to be competent and can give consent for their own treatment. If a 16 or 17 year old consents to treatment a parent cannot over-ride that consent. This applies equally to young people with capacity who are to be admitted (informally) to hospital for treatment for a mental disorder.

108. It is not a legal requirement but it is advisable to include the child/young person's family in discussions regarding treatment. However, this can only be done with the consent of the child/young person.

See Appendix D for guidance on assessing whether a child is *Gillick* competent.

Children who are not competent to consent to treatment

109. If the child is not competent to give consent, then the healthcare professional may give treatment on the basis of parental consent. Parental consent may be given by any person who has parental responsibility for the child, provided that person has capacity to give such consent. This may not necessarily be the parents but, for convenience, "parents" in this policy means all persons with parental responsibility.

110. Healthcare professionals need to make reasonable enquiries as to who holds parental responsibility for the child. Every effort should be made to include all those with parental responsibility in discussions regarding treatment options.

111. Not all parents have parental responsibility for their children. For example, unmarried fathers do not automatically have such responsibility but they can acquire it. If you have any doubt about whether the person with the child has parental responsibility for that child, you must check. The Children Act 1989 (which applies to both children and young people) sets out the persons who may

have responsibility for a child.

Parental responsibility is vested in:

- the mother automatically on the birth of the child
- the father if his name has been registered on the child's birth certificate (this only applies to births from 1st December 2003)
- the father/partner when he/she is married to the mother at the time of the birth
- an unmarried father can acquire parental responsibility in the following ways:-
    - by jointly registering the birth with the mother (only applies to births from 1st December 2003)
    - by entering into a Parental Responsibility Agreement with the mother
    - by applying to the courts for a Parental Responsibility Order
    - by being appointed as guardian either by the mother or the court (although he will usually only assume parental responsibility upon the mother's death)
    - by obtaining a residence order
    - by marrying the mother and agreeing with her that he will assume parental responsibility
    - marrying the mother and upon his application to the court
    - by adopting the child
- legally appointed guardian
- a person who has been granted a residence order in respect of the child
- a step-parent who has entered into a Parental Responsibility Agreement with the mother
- a local authority in whose favour a care order has been made[8]
- a person who has been granted an emergency protection order
- an adopter of a child in accordance with section 46 of Adoption and Children Act 2002
- a husband and wife in whose favour a parental order has been made under section 30 of the Human Fertilisation and Embryology Act 1990

[8]Care should be sought as a Local Authority has the power to restrict the parental responsibility of the parents in relation to health care. It should always be established who has parental responsibility when an order is made and in what circumstances the parental responsibility can be exercised.

- an adoption agency in accordance with section 25 of the Adoption and Children Act 2002
- the court in wardship procedures
- some same-sex partners in certain situations

112. If you are in any doubt about whether a person has parental responsibility or whether a parent is acting in the best interests of the child you should seek legal advice.

113. Consent is usually only needed from one person holding parental responsibility. However, there have been legal cases where the Court has advised that all parties with parental responsibility must give consent; if consent cannot be agreed an order from the Family Division of the High Court must be obtained. Those cases have included:

- sterilisation for contraceptive purposes
- non-therapeutic male circumcision
- contested issues of immunization.

114. Where consent is being given on behalf of a child who is not competent to consent, the healthcare professionals, the child and the person with parental responsibility must meet to discuss and consider treatment options. This is particularly important if more than one person has parental responsibility for a child.

115. When children who are not competent to give consent are being cared for in hospital, it may not seem practicable to seek the consent of the parents on every occasion for every routine intervention such as blood or urine tests or X-rays. However, healthcare professionals should remember that, in law, such consent is required, although consent may be given in advance. Where a child is admitted, the healthcare professional should discuss with the parents what routine procedures will be necessary, and, if it is not practicable to seek consent for every intervention, they may ask the parents if they are content to give their consent in advance for these routine procedures. If the parents are not content to give their consent, then consent should be obtained on every occasion. The parents may specify that they wish to be asked before particular procedures are initiated. You must then do so, unless the delay involved in contacting them would put the child's health at risk.

116. It is important to be aware that neither an Emergency Protection Order (EPO) nor a Police Protection Order (PPO) confers the consent for examination. If the person who has parental responsibility in not available, consent with directions, must be obtained from the Family Division of the High Court.

117. A healthcare professional should not rely on the consent of a parent if he or she has any doubts about whether the parent is acting in the best interests of the

child. In order to consent on behalf of a child, the person with parental responsibility must also have mental capacity themselves.

118. For forensic examinations different rules may apply.

Young people (age 16 to 17 years) without capacity to consent to treatment

119. Healthcare professionals must follow the Mental Capacity Act when the young person lacks capacity to decide about treatment.

Children who are competent or young people (aged 16 or 17) with capacity who refuse treatment

120. Healthcare professionals should be very careful in cases where a young person or child refuses treatment. Such cases can be controversial and raise complex legal issues. Healthcare professionals should have particular regard to chapter 3 of the Guide If there is any doubt about how to proceed it is recommended that advice be sought from the Clinical Law and Ethics Advisors via: BCU.Consent@wales.nhs.uk. If they are unavailable and the matter is urgent, please contact the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk. Out of hours, please contact Bronze on call via switchboard. if there is any doubt about how to proceed

121. Where a young person of 16 or 17 who has capacity, or a child under 16 who has been assessed as "*Gillick*" competent, refuses treatment, a person with parental responsibility for the child / young person or the Courts can be used as alternative sources of consent [9]. In such circumstances legal advice should be sought. See Appendix C.

122. Where a child has refused treatment, and a decision is made to give treatment on the basis of parental consent, it must be exercised on the grounds that the welfare of the child is paramount. The psychological effect on the child of having their decision over-ruled must also be considered.

123. Where a young person aged 16-17 who has capacity is to be admitted to hospital for treatment for a mental disorder, the MHA provides that where that person refuses to be admitted to hospital for treatment for a mental disorder, a person with parental responsibility for that person cannot overrule that refusal. The MHA should be used where appropriate.

Person with parental responsibility refusing treatment

124. If consent for treatment is refused by one or more of those with parental responsibility, or where an agreement cannot be reached between the persons with parental responsibility, seek legal advice. See Appendix C.

9 *NHS Trust v X (In the matter of X (A Child) (No 2))* [2021] EWHC 65 (Fam) (18 January 2021) (bailii.org)

Young people aged 16 and 17 who refuse life-sustaining treatment

125. Where a young person aged 16 or 17 refuses life-sustaining treatment (e.g. a blood transfusion on the basis of their religious conviction) healthcare professionals should exercise extreme caution. In these circumstances, legal advice should be sought and, if necessary, the matter should be referred to the court. See Appendix C.

126. The management of a young person in an emergency situation, who is likely to die or suffer serious permanent harm without immediate treatment, is viewed in law in a different light. There may not even be time for emergency application to the court. Senior clinicians may decide to treat without consulting the court. Parents may not prevent clinicians from administering treatment to their children if their child's life or health is in imminent danger. This includes cases where the parents wish to refuse blood products for their child on religious grounds. Staff may rely on the support of the courts to endorse decisions that are taken in good faith and in the best interests of the young person concerned. It is important, however that two doctors of consultant status should make an unambiguous, signed and dated entry in the patient's medical notes that the treatment is essential to save life or prevent serious permanent harm. The doctor who stands by and allows a 'minor' patient to die in circumstances where treatment might have avoided death may be vulnerable to criminal prosecution.

127. The courts have often commented that such a situation does not detract from the loving and responsible reputation of the parents involved, and they have stressed the need for parents to be fully informed of the clinical developments regarding their child and of the intended action by clinicians.

128. When treating children or young people in these circumstances, healthcare professionals should consider carefully the guidance in chapter 5 of the Guide.

Parents refusing life-sustaining treatment for a child

129. Where a parent or parents intend to refuse life-sustaining treatment for a child under the age of 16, staff must always seek legal advice (see Appendix C). The well-being of the child is paramount and, if the parents refuse to give permission for the treatment, it may be necessary to apply for a court order to administer the treatment lawfully. Healthcare professionals should note that a court order can be obtained out of hours when necessary.

Emergency treatment

130. A life threatening emergency may arise in connection with a child when consultation with either a person with parental responsibility or the court is impossible, or the persons with parental responsibility refuse consent despite such emergency treatment appearing to be in the best interests of that child. In such cases the courts have stated that doubt should be resolved in favour of the preservation of life and it will be acceptable to undertake treatment to preserve life or prevent serious damage to health.

8. Patients who lack capacity to give or withhold consent

131. In determining whether a patient aged 16 years and over lacks the mental capacity - either temporarily or permanently - to give or withhold consent for themselves, healthcare professionals must act in accordance with the MCA. A patient who lacks capacity can be given treatment if it is in their best interests, as long as the patient (when aged 18 years and over) has not made a valid and applicable advance decision refusing that specific treatment.

132. When treating patients who may lack capacity, healthcare professionals must have due regard for the MCA Code of Practice.

Does the patient have capacity?

133. The MCA applies in relation to determining whether a patient has capacity to give their consent. It is a key principle of the MCA that a patient is assumed to have capacity to make decisions for themselves unless it is established on the balance of probabilities that they do not.

134. In ascertaining a patient's capacity, the healthcare professional must not make a judgment on the basis of the patient's age, appearance, assumptions about their condition or any other aspect of his or her behavior. It is important to take all possible steps to try and help the patient make a decision for themselves (see chapter 3 of the MCA Code of Practice). Where there is doubt about a patient's capacity, an assessment should be carried out and the healthcare professional must be able to justify their conclusions.

135. It is the healthcare professional proposing treatment or examination who should assess the patient's capacity to consent. More complex decisions are likely to need more formal assessments, which may include a professional opinion (for example from a speech and language therapist/psychologist), but the final decision about the patient's capacity must be made by the person intending to carry out the action.

136. Healthcare professionals who carry out actions related to the care and treatment of patients who lack capacity to consent to them at that time may be protected from liability if they reasonably believe (having assessed the patient's capacity where there is doubt) that the patient lacks capacity to make that particular decision at the time it needs to be made and the action is in the patient's best interests. (For further guidance see chapter 6 of the MCA Code of Practice and note that the MCA imposes limitations on acts which can be carried out with protection from liability – including where there is inappropriate use of restraint or where the patient who lacks capacity is deprived of their liberty).

137. A patient lacks capacity if he or she is unable to make a specific decision for themselves in relation to a matter at the time it needs to be made because they have an impairment or disturbance of the mind or brain. This impairment or

disturbance can be either temporary or permanent.

138. The MCA provides that a patient with an "impairment or disturbance" is unable to make a decision if they are unable to do one or more of the following:
    a) understand the information relevant to the decision; or

    b) retain that information; or

    c) use or weigh that information as part of the process of making the decision; or

    d) communicate his or her decision, whether by talking, using sign language or any other means.

139. If a patient cannot do one or more of these as a result of their impairment they will be treated as being unable to make the decision. Point d) only applies in situations where the patient cannot communicate their decisions in any way.

140. The British Medical Association has published advice on the assessment of capacity - www.bma.org.uk/

141. Capacity should not be confused with a healthcare professional's assessment of the reasonableness of the patient's decision. The patient is entitled to make a decision which is based on their own religious belief or value system, even if it is perceived by others to be unwise or irrational.

142. Where there is any doubt about a patient's capacity to make a particular decision, after support has been provided without success, an assessment must be carried out. This should be done in accordance with the requirements of the Mental Capacity Act 2005 and the assessment must be recorded e.g. using Form 4.

143. An apparent lack of capacity to give or withhold consent may in fact be the result of communication difficulties rather than genuine incapacity. The healthcare professional undertaking the assessment of capacity is required by the MCA to take all practicable steps to help the patient make the decision, therefore they should involve appropriate colleagues, such as specialist learning disability teams and speech and language therapists, unless the urgency of the patient's situation prevents this. If at all possible, the patient should be assisted to make and communicate their own decision, for example by providing information in non-verbal formats where appropriate.

Advance decisions to refuse treatment (ADRT)

144. In accordance with the MCA, a person who is 18 or over and has capacity can make an ADRT. An ADRT may be withdrawn or altered at any time whilst the person has capacity.

145. Any ADRT that is valid and applicable to the treatment that is proposed is legally binding. A healthcare professional must follow a valid and applicable ADRT. If they do not, they could face criminal prosecution and or civil liability.

146. A valid and applicable ADRT that is made after a Health and Welfare LPA overrules the decision of any Attorney.

147. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder, a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 and 4A of the MHA and consent is not required. Informal patients are not covered by Part 4 of the MHA and their advance decisions refusing treatment are enforceable if valid and applicable.

Validity of an ADRT

148. An ADRT is valid if made voluntarily by an appropriately informed adult (aged 18 years or over) with capacity.

149. An ADRT is **not** valid if the individual:

    a) was under 18 years of age when it was drawn up; or

    b) did not have capacity when the decision was made; or

    c) was acting under duress; or

    d) has withdrawn the advance decision (verbally or in writing) at a time when he/she had capacity to do so; or

    e) has done anything else clearly inconsistent with the ADRT remaining his fixed decision; or

    f) creates a LPA after the date when the ADRT was made, conferring authority on the attorney to give or refuse consent to the treatment to which the ADRT relates.

150. Healthcare professionals should ensure that the ADRT that is being considered has been regularly reviewed and updated. However, ADRT made long in advance of incapacity are not necessarily invalid unless, for example, there are reasonable grounds for believing that circumstances have since arisen which mean the patient would have changed their mind if they still had capacity. For example, there may be a medical advancement which the patient was unaware of at the time he or she made the advance decision, which could significantly improve their condition.

151. There are no specific legal requirements concerning the format of an ADRT (unless it involves life-sustaining treatment – see below). It may be a written document, a witnessed verbal statement, a signed printed card, a smart card, or a note of discussion recorded in a patient's health record. Although there is no legal requirement, if possible patients should be encouraged to put their ADRT in writing so that there is a clear record of their wishes.

152. If an ADRT relates to refusal of life-sustaining treatment, it will only be valid if it is in writing, contains the words 'even if life is at risk' (or words to that effect) and is signed, dated and witnessed.

Applicability of an ADRT

153. An ADRT must clearly specify the treatment that is being refused and in what specific circumstances it applies. It must be unambiguous and applicable to present circumstances. If the decision to be made falls outside of the scope of the ADRT, it will not be applicable.

154. An ADRT cannot authorise anyone to do anything which is unlawful (for example assist an individual in committing suicide), or make anyone carry out a particular treatment.

Responsibility of healthcare professionals

155. It is the responsibility of the person making the ADRT to ensure that it will be drawn to the attention of healthcare professionals when it is needed. However, healthcare professionals are also responsible for asking patients or their representatives about the existence of ADRT.

156. If a healthcare professional knows or has reasonable grounds to believe that an ADRT exists, and time permits, then they should make reasonable enquiries regarding its existence and content. Emergency treatment should not be delayed in order to look for an ADRT if there is no clear indication that one exists.

157. If an ADRT relates to refusal of life-sustaining treatment, then the healthcare professional must see a written, signed and witnessed ADRT which contains the words 'even if life is at risk' (or similar).

158. A healthcare professional will not be acting unlawfully if he or she treats a patient and is genuinely unaware of the existence of an ADRT. Similarly, they will not act unlawfully if they act in accordance with an ADRT that they believe is valid and applicable at the time but is later proved invalid / not applicable.

159. If there is any doubt about the validity or applicability of an ADRT it may be necessary to refer the matter to the Court of Protection (CoP). In this situation, healthcare professionals may provide life-sustaining treatment or treatment that prevents serious deterioration in the patient's condition whilst the decision of the court is awaited.

160. If an ADRT is not valid and applicable, it should still be noted as an expression of the patient's feelings and wishes about what should happen to them, and should be taken into account in deciding what is in their best interests.

Advance statements

161. An advance statement is different to an advance decision to refuse treatment in that it generally outlines a patient's wishes or preferences in relation to care or treatment that they want to have, as opposed to being a refusal of treatment. Although an advance statement is not legally binding it should be noted as an expression of the patient's feelings and wishes about what should happen to them if they lack capacity to decide for themselves, and should be taken into account in deciding what is in their best interests.

162. Some advance statements will express the patient's wishes that a particular course of action should be taken or that they should receive a particular type of treatment in the event that they no longer have capacity. The healthcare professional is not under a legal obligation to provide treatment because the patient demands it. The decision to treat is ultimately a matter for his or her professional judgement acting in the context of a best interests decision. In making that decision the healthcare professional will, however, be required to take into account the patient's wishes as expressed in determining what is in his or her best interests.

163. Further information about ADRT is available in chapter 9 of the MCA Code of Practice.

Decisions made in the patient's best interests

164. In determining what is in the patient's best interests, the healthcare professional must look at the patient's circumstances as a whole and not just at what is in the patient's best medical interests. They must try to work out what the patient would have wanted if he or she had capacity, rather than what that professional believes to be in his or her best interests. The healthcare professional must make all reasonable efforts to ascertain:

    - the patient's past and present wishes and feelings,
    - any beliefs and values that would be likely to influence the patient's decision, and
    - any other factors that the patient would be likely to consider if they were making the decision.

165. Lack of capacity to make the decision in question will not automatically mean that the patient is unable to participate in the decision making process, and every assistance should be given to enable him or her to do so.

166. A healthcare professional must not make assumptions about someone's best interests simply on their age, appearance, condition or behaviour. They should also consider whether the patient is likely to regain capacity and if so whether the decision can be deferred.

167. They must also, so far as is practicable, consult representatives of the patient to see if they have any information about the patient's wishes, feelings, beliefs and values. In particular, they should try to consult:

- any unpaid person who is named by the patient as a person who should be consulted on such matters
- anyone engaged in caring for the patient or interested in his welfare
- any person who has been granted a LPA by the patient; and
- any deputy appointed for the patient by the CoP to make decisions for that patient.

168. The purpose of consulting is to ascertain what the patient would have wanted if they had capacity, not what the persons consulted believe should happen. Where a patient has made a Health and Welfare LPA or a deputy of the CoP (for personal welfare) has been appointed, and if it is within their authority, it will be for the attorney or deputy to make the decision on the patient's behalf. However, they too must act in the patient's best interests and, where practicable and appropriate, consult the people indicated above.

169. If a patient has no one who can be consulted, healthcare professionals must consider whether the circumstances are such that an Independent Mental Capacity Advocate (IMCA) should be instructed (see below).

170. If the patient has made an advance statement (other than a valid and applicable ADRT), then the healthcare professional should still take that statement into account in deciding what is in the patient's best interests, as it is a reflection of the patient's wishes and feelings. However, if it is the healthcare professional's judgement that to act in accordance with the advance statement would not be appropriate and not in the patient's best interests, he or she is not bound to do so.

Temporary incapacity

171. Patients may suffer a temporary loss of capacity, for example, where they are under a general anaesthetic or sedation, or unconscious after a road accident. As with any other situation, an assessment of that patient's capacity must only examine their capacity to make a particular decision when it needs to be made. Unless the patient has made a valid and applicable ADRT of which you are aware, then they may be treated insofar as is reasonably required in their best interests pending recovery of capacity. This will include, but is not limited to, routine procedures such as washing and assistance with feeding. If a medical intervention is thought to be in the patient's best interests but can be delayed until the patient recovers capacity and is able to consent to (or refuse) the intervention, it must be delayed.

Fluctuating capacity

172. It is possible for a patient's capacity to fluctuate. In such cases, it is good practice to establish whilst the patient has capacity their views about any clinical intervention that may be necessary during a period of incapacity and to record these views. The patient may wish to make an advance decision to refuse certain types of treatment (see paragraphs 144 to 160). If the person does not make a relevant ADRT, the patient's treatment when incapacitated should accord with the principles for treating the temporarily incapacitated (see above).

Lasting Power of Attorney (LPA)

173. LPA was introduced by the MCA. An LPA may be executed by any person of 18 years or over whilst they have capacity and takes effect when they no longer have capacity. A Health and Welfare LPA appoints a person to act as an attorney to make decisions about a person's welfare and medical treatment when that person lacks the capacity to make that particular decision. The attorney acting under a Health and Welfare LPA must make the decision in the person's best interests. The LPA must be registered with the Office of the Public Guardian (OPG) before it can be used and it is essential that healthcare professionals see a summary on the OPG website or the LPA document[10] to confirm that it has been registered, and to assure themselves of the authority that it confers on Attorney(s). An LPA does not authorise an attorney to refuse or give consent to life-sustaining treatment unless this is explicitly stated in the LPA. If two or more people have been appointed as attorneys, they may either be appointed to act jointly or jointly and severally. If they are acting jointly, any decision must be made by consensus. However, if they are acting jointly or severally, then either of the attorneys can make a decision independently of the other.

174. If the patient has made a valid and applicable ADRT to refuse treatment, then this can be overridden by an attorney providing that the LPA was made after the advance decision and his or her authority under the LPA extends to making decisions about treatment that is the subject of the advance decision. An attorney, like any person who is making a decision on behalf of a patient who lacks capacity, must act in accordance with the MCA and must have regard to the MCA Code of Practice.

175. When acting on the basis of a decision by an attorney, a healthcare professional should, so far as is reasonable, try to ensure that the attorney is acting within their authority. Any disputes between a healthcare professional and an attorney that cannot be resolved, or cases where there are grounds for believing that the attorney is not making decisions that are in the best interests of the patient, should be referred to the CoP.

Court Appointed Deputies (CAD)

176. Whilst a decision made by the Court is always preferred, the MCA now provides that the Court can appoint deputies to make decisions on its behalf. This may be

[10] [1] It is considered good practice for a physical copy to be retained within the patient health record

necessary if there are a number of difficult decisions to be made in relation to the patient. The CAD will normally be a family member, partner, friend or person who is well known to the patient. Healthcare professionals must always ensure that they see a sealed (CoP stamp) copy of the deputyship order so that they are clear what authority the CAD holds.

177. As with attorneys appointed under a LPA, a CAD may only make decisions where they have reasonable grounds to believe that the person they are acting for does not have capacity, and any decisions they take will be strictly limited to the terms specified by the Court and in accordance with the MCA. A CAD is also subject to a number of restrictions in the exercising of their powers. For example, a CAD cannot refuse consent to the carrying out or continuation of life-sustaining treatment for the patient, nor can he or she direct a person responsible for the patient's healthcare to allow a different person to take over that responsibility**.** A deputy cannot restrict a named person from having access to the patient.

178. Healthcare professionals should co-operate with the CAD with the aim of doing what is best for the patient. Where a CAD acting within their authority makes a decision that a treatment (that is not life-sustaining) should be withheld or withdrawn the healthcare professional must act in accordance with those instructions. However, a CAD cannot require a healthcare professional to give a particular type of treatment, as this is a matter of clinical judgement. In such cases where a healthcare professional has declined to give treatment, then it is good practice to seek a second opinion, although the CAD cannot insist that the healthcare professional steps aside to allow another professional to take over the case. A CAD is supervised by the OPG, and where a healthcare professional suspects that a deputy is not acting in the interests of the patient, he or she should refer the matter to the Public Guardian.

179. A valid and applicable ADRT overrules the decision of the CAD.

Independent Mental Capacity Advocates (IMCA)

180. If a patient aged 16 years or older who lacks capacity is to receive serious medical treatment, and that patient has no one else to consult and support them other than paid or professional staff, then unless a decision has to be made urgently (e.g. to save the person's life), an IMCA must be instructed. The duty to instruct rests with the Health Board in the case of treatment provided in hospital. (Note that there are other situations when an IMCA must be instructed – e.g. decisions about whether to place people into accommodation (for example a care home or a long stay hospital and under the Deprivation of Liberty Safeguards.)

181. The role of the IMCA is to represent and support the patient. They will not make decisions on the patient's behalf. Such decisions will still be made by the healthcare professional on the basis of what is in the patient's best interests. However, the IMCA will speak to the patient and, so far as possible, try to engage them in the decision process. They will assist in determining what is in the patient's best interests and the healthcare professional must take into account the views of the IMCA in deciding what actions to take. The IMCA is entitled to information about the patient and to see his or her relevant health records.

182. Where serious medical treatment is proposed, they will discuss with the professional the proposed course of treatment or action and any alternative treatment that may be available and may, if they consider it necessary, ask for a second medical opinion.

183. Serious medical treatment for this purpose means treatment which involves providing, withdrawing or withholding treatment in circumstances:

- where there is a fine balance between the benefits and burdens the treatment would have on the patient and taking into account the likely risks
- where there is a choice of treatments, a decision as to which one to use is finely balanced or
- what is proposed would be likely to involve serious consequences for the patient

Referral to the Court of Protection

184. Where there are difficult or complex decisions to make on behalf of a patient who lacks capacity, the matter must be referred to the Court of Protection if all other options for making the decision or resolving differences have been exhausted.

185. The Court of Protection can deal with any matters covered by the Mental Capacity Act 2005, such as:

- whether the patient has capacity to make a particular decision
- whether an ADRT is valid and applicable
- what course of action/decision would be in a patient's best interests
- where there is a dispute between healthcare professionals, members of the family, partners, carers or any other interested persons such as an Independent Mental Capacity Advocate or the attorney of a Lasting Power of Attorney about what is in the patient's best interests
- where there is doubt about whether the patient lacks capacity to make a decision for themselves and is not likely to regain capacity in the short term
- where treatment of an experimental nature is proposed.

186. Where a patient lacks capacity then ***a referral to the Court must be made*** in the following circumstances:

- where it is proposed that the patient should undergo non-therapeutic sterilisation (e.g. for contraceptive purposes)

- cases involving organ or bone marrow donation by a patient who lacks capacity to consent;
- where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)
- where there are doubts or a dispute about whether a particular treatment would be in the best interests of the patient.

This is not an exhaustive list and the courts may extend the list of procedures that should always be referred. Legal advice should be sought

187. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision and that the clinical decision to withdraw Clinically Assisted Nutrition and Hydration (CANH) is reasonable in the circumstances, given the diagnosis, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. The second clinical opinion should be sought from a consultant with experience of PDOC, who has not been involved in the patient's care and who should, so far as reasonably practical, be external to this Health Board. The consultant should examine the patient and review the patient's medical notes and the information that has been collected. Healthcare professionals should make a very detailed entry/record in the medical notes, outlining any relevant discussions or meetings that have taken place and the reasons for the opinion that has been provided and also full note of all discussions, meetings and reasons for decisions reached. Legal advice can be sought to support the decision.

188. The Court has held that therapeutic abortion and sterilisation where there is a medical necessity does not automatically require a referral, although such procedures can give rise to special concern about the best interests and rights of a patient who lacks capacity. In the case of a patient with learning disabilities, it is good practice to involve a learning disability consultant psychiatrist, the multidisciplinary team and the patient's family/partner as part of the decision-making process and to document their involvement. Less invasive or reversible options should always be considered before permanent sterilisation.

189. Appendix C provides advice for healthcare professionals who need legal advice when they are faced with a situation that may require the intervention of the Court of Protection. Guidance on referring matters to the Court of Protection has also been issued by the General Medical Council and the BMA.
Decision making and consent - ethical guidance - GMC (gmc-uk.org)
https://www.bma.org.uk/advice/employment/ethics/mental-capacity/mental-capacity-toolkit/12-court-of-protection-and-court-appointed-deputies

190. Where an adult or young person has been assessed to lack the capacity to give or withhold consent to a significant intervention, this fact should be documented on Form 4: Treatment in best interests (see chapter 2 of this policy) along with full details of the assessment of capacity and best interests.

9. Human Tissue

Removal, storage and use of human tissue

191. The Human Tissue Act 2004 (HTA 2004) makes consent the fundamental principle underpinning the lawful retention and use of body parts, organs and tissue from the living or deceased for specified health related purposes and public display. Human tissue is defined as material which has come from a human body and consists of, or includes human cells. Live gametes and embryos are excluded as they are regulated under the Human Fertilisation and Embryology Act 1990 (HFEA).

192. The Human Tissue Act Codes of Practice and Standards issued by the Human Tissue Authority (HTA) contain detailed provisions on consent to the storage and use of relevant material from the living and the deceased. The Codes and Standards can be found on the following link - Codes of Practice | Human Tissue Authority (hta.gov.uk)

193. The HTA 2004 creates an offence of DNA theft. It is unlawful to obtain and store human tissue with the intention of its DNA being analysed, without consent of the patient from whom the tissue was obtained.

194. The HTA 2004 allows material taken from the living to be stored and used without consent for the following scheduled purposes on the basis that these are bound up with the general provision of clinical and diagnostic services:

- clinical audit
- education or training relating to human health
- performance assessment
- public health monitoring and
- quality assurance

195. However, if a patient actively objects to the use of their samples for such purposes, then that objection should be complied with. The Act and the Code contain a complex set of rules around the need for consent being required for the above purposes if the tissue is removed after death. There is also a set of rules about relevant material taken from a patient in their lifetime continues to be

treated as such after death. It is the point at which the material is removed that determines how it is affected by the Act. The Code refers to concepts such as nominated representatives and qualifying relationships for the purpose of consent. It is too detailed to quote fully here and it should be consulted where relevant decisions need to be made.

196. Consent is required to store and use tissue removed from the living for:

- obtaining scientific or medical information about a patient which may be relevant to any other person (now or in the future)
- public display
- research into disorders, or the functioning of the human body and
- transplantation.

197. The system must be well-publicised and transparent, making provision for patients to record their consent or objection to the use of such tissue and for this to be notified to the laboratory. Patients must also be able to record any objections to particular uses or use of particular tissues.

198. In the Health Board written consent must be obtained from the patient either at the time of their procedure, or retrospectively, to indicate whether or not they give their consent to the use of removed tissue for a specific research project. Please refer to the Health Board's Standard Operating Procedure – MORT/0064 – Consent (Post mortem).

Consent to post mortem examinations

199. Please refer to the following Pathology Standard Operating Procedures:

- MORT/0064 – Consent (Post mortem)

200. If a post mortem examination is ordered by the coroner, the consent of relatives is not required.

201. Other post-mortem examinations are hospital post-mortem examinations which are usually carried out at the request of doctors who have been caring for the patient or, sometimes, at the request of close relatives wishing to find out more about how a patient died. In some circumstances it may be appropriate to limit the examination to a particular region of the body.

202. All post mortems are carried out under an HTA licence held by the Health Board. It is a requirement of the HTA 2004 that appropriate consent is taken before a post-mortem can be carried out or any other tissue removed from the body of a deceased person. This consent must be obtained from a person in a "qualifying

relationship" (see also above). The request for a hospital post-mortem should be made by the Clinician who, after discussions, will liaise with the appropriate persons to ensure all statutory requirements are met.

203. For further information on post mortems the *Human Tissue Authority Code of Practice – Post Mortem Examination (Code B, 2012)* should be consulted. For further information on retention of tissues, organs and body fluids, please seek advice from the pathologist.

Transplantation - Living Donation

204. The HTA is responsible for the regulation, through a system of approvals, of the donation from living people of solid organs, bone marrow and peripheral stem cells for transplantation into others. Information on the legal requirements is available - https://www.hta.gov.uk/

Transplantation - Deceased organ donation

205. Consent to organ donation in Wales is governed by the Human Transplantation (Wales) Act 2013. There is an associated Code of Practice - https://bts.org.uk/wp-content/uploads/2018/01/HTA_CoP_on_Human_Transplantation_Wales_Act_2013_-_Final_-_May_2014.pdf. This system operates on the basis of deemed consent; it is assumed that the individual had no objection to organ donation unless they have registered or expressed a decision not to donate their organs following their death. Patient representatives should be consulted to obtain any evidence that a patient did not wish to be an organ donor.

206. Express consent to organ donation is required where a patient has not been an ordinary resident in Wales for more than 12 months before dying

10. Clinical photography, video recordings and audio recordings

Making and using visual or audio recordings of patients

207. This chapter focuses on the consent aspect of making photographic, video or audio recordings of patients. 'Recordings' in this chapter means originals or copies of audio recordings, photographs and other visual images of patients that may be made using any recording device e.g. video.

208. Visual and audio recordings of patients may be made for any of the following reasons:

- As part of assessment, investigation or treatment of a patient, to be kept in the patient's medical notes.
- For use in teaching, training or assessment of fellow healthcare professionals and students or other appropriate groups e.g. at a conference - injury - see IG17 – Procedure for the Non-Clinical Photography or Video / Audio Recording of Patients or Staff.
- For use in clinical research - injury - see IG17 – Procedure for the Non-Clinical Photography or Video / Audio Recording of Patients or Staff.
- For publication e.g. in a book, a journal, a patient information leaflet, on a poster or in publicity material, any of which may also be accessible on the internet - injury - see IG17 – Procedure for the Non-Clinical Photography or Video / Audio Recording of Patients or Staff.
- As potential evidence e.g. following injuries sustained as the result of an accident or an assault or where there is suspected non-accidental injury - see IG17 – Procedure for the Non-Clinical Photography or Video / Audio Recording of Patients or Staff.

209. Because it is sometimes possible for people to be identified by tattoos or other distinguishing marks or features, or from the sound of their voice in an audio recording, it is this Health Board policy that written consent must always be obtained prior to making a visual or audio recording of a patient or their art work for any of the purposes described in paragraph 208 (for exceptions see paragraph 215 below).

210. Healthcare professionals should always ensure that they ask for a patient's written consent in advance if any photographic, video or audio recording will result from a procedure (unless the patient is temporarily unconscious – see paragraph 224).

211. If you only obtain consent for use of photographic, video or audio recordings as part of treating or assessing a patient you must not use them for any purpose

other than the patient's care or the audit of that care, without obtaining further consent from the patient.

General Principles

212. When making or using recordings you must respect the patient's privacy and dignity and their right to make or participate in decisions that affect them. The following general principles apply to most photographic, video and audio recordings:

- seek permission to make the recording and get consent for any use or disclosure.
- give patients adequate information about the purpose of the recording when seeking their permission.
- make recordings only when you have appropriate consent or other valid authority for doing so.
- ensure that patients are under no pressure to give their permission for the recording to be made.
- stop the recording if the patient asks you to, or if it is having an adverse effect on the consultation or treatment.
- do not participate in any recording made against a patient's wishes.
- eyes or faces must not be blacked out in an attempt to conceal identity after the recording has been made. Every effort must be made to conceal the identity of the patient whilst the recording is being taken. You must ensure that the patient is informed if their face will be visible or they will be identifiable in any other way in the recording.
- ensure that the recording does not compromise patients' privacy and dignity.
- do not use recordings for purposes outside the scope of the original consent for use, without obtaining further consent.
- make appropriate secure arrangements for storage of recordings.

213. Before the photograph, video or audio recording is made, healthcare professionals must ensure that patients:
    - understand the purpose of the recording, who will be allowed to see/hear it, the circumstances in which it will be shown/played, that copies are likely to be made if the recording is for educational purposes, and that the recording will be stored securely within the Health Board.

- understand that, in the case of publication, they will not be able to withdraw their consent or control future use of the material, once the recording is in the public domain.

- understand that withholding permission for the recording to be made, or withdrawing permission during the recording, will not affect the quality of care they receive.

- are given time to read explanatory material and to consider the implications of giving their written permission. Explanatory material should not imply that permission is expected. It should be written in language that is easily understood. If necessary, translations should be provided.

- have completed and signed consent form which is broken down into granular statements for the various purposes, clearly indicating which statements they consent to and which ones they don't.

214. After the recording, the healthcare professional must ensure that:

- patients are asked if they want to vary or withdraw their consent to the use of the recording.

- recordings are used only for the purpose for which patients have given consent.

- patients are given the chance, if they wish, to see the recording in the form in which it will be shown.

- recordings are given the same level of protection as with patient's medical notes against improper disclosure.

- if a patient withdraws or fails to confirm consent for the use of the recording, the recording is not used and is erased as soon as possible

Recordings for which consent is not required

215. Permission and consent is not needed to make or use the recordings listed below, provided that, before use, they are effectively anonymised by the removal of any identifying marks or text (writing in the margins of an x-ray or patient labels, for example):

- Images taken from pathology slides

- X-rays

- Laparoscopic or endoscopic images

- Images of internal organs (however, it is best practice to obtain written consent if the recording is to be used in education or publication and will be

accompanied by verbal or written information which may enable inadvertent identification of the patient)

- Recordings of organ functions
- Ultrasound images

Children and young people

216. Where children lack the understanding to give their permission to photographic, video or audio recordings, healthcare professionals must get permission to record from the person with parental responsibility. Children under 16 who have the competence to give permission for a recording may sign the consent form themselves. Healthcare professionals should make a note of the factors taken into account in assessing the child's competence. Young people are assumed in law to be competent and can give permission to recordings themselves, unless they lack capacity.

217. In cases of suspected non-accidental injury of a child, photographs may be taken without parental consent if necessary. However, these photographs must only be used as part of the clinical record, or as potential evidence. They must not be used for education, publication or research without written consent. If written consent is given for use in education, publication or research, it is recommended that images are not used for these purposes before or during likely legal proceedings.

Vulnerable adults

218. In the case of suspected non-accidental injury of a vulnerable adult, efforts should be made to obtain written consent to the taking and use of photographs as potential evidence.

219. If the patient is unwilling for recordings to be made for evidential purposes, then the patient should still be asked for consent to photographs being taken for their clinical record, if it is a valid addition to the record, or if it is not appropriate to seek their consent for evidential purposes at that time e.g. if the alleged perpetrator is present. Photographs taken for the clinical record should not be used as evidence, unless, at a later date, the patient changes their mind or legal advice is received to the contrary for reasons such as receipt of a police request or court order. In this case the consent form can be modified at this later date, and these modifications must be signed and dated by the patient.

Fetal loss, stillbirth and neonatal death

220. Photographs taken solely for the purpose of giving them to the bereaved parents do not qualify as clinical photographs and therefore do not come under the auspices of this policy. Photographs taken on behalf of the bereaved must not be used for any other purpose without written consent from the person with parental responsibility.

221. If photographs are required for any other purpose (except during the course of a post mortem examination) the written consent of those with parental responsibility must be obtained.

Adults and young people who lack the capacity to consent for themselves

222. When adults or young people lack capacity to make a decision about an audio or visual recording for themselves, any decision must be made in accordance with the MCA.

223. As a general principle you should not make, or use, any such recording if the purpose of the recording could equally well be met by recording patients who are able to give or withhold consent.

224. The situation may sometimes arise where the patient is temporarily unable to give or withhold consent because, for example, they are unconscious. In such cases, you may make such a recording, but you must seek consent as soon as the patient regains capacity. You must not use the recording until you have received consent for its use, and if the patient does not consent to any form of use, the recording must be destroyed.

Adults and young people who lack capacity - Recordings made as part of clinical care, or as potential evidence

225. If it can be demonstrated that it is in the patient's best interests, then photographs, video and audio recordings can be made as part of the patient's clinical care, or as potential evidence. If someone holds a Health and Welfare LPA or is a CAD, they should be asked to consent on behalf of the patient. Otherwise the healthcare professional making the recording must confirm that they have assessed capacity and are acting in the patient's best interests.

Adults and young people who lack capacity - Recordings made for education and publication

226. If adults or young people lack capacity to make a decision about photographs, video or audio recordings for themselves, then recordings can only be taken and used for education or publication if it has been determined to be in the patient's best interests.

Patients who have capacity but are unable to sign the consent form

227. Physical inability to sign a consent form does not detract from an individual's ability to give consent. Patients can indicate their consent verbally or non-verbally, in the presence of a witness, who should then sign the consent form to confirm that the patient's consent was given. Recordings can then be used in the same way as if the patient had signed the consent form.

Withdrawal of consent

228. Patients have the right to withdraw consent for the use of their audio or visual records at any time, although they should be made aware that where another legal basis applies, for example compliance with other legislation, their lack of consent may potentially be overridden. The withdrawal should be documented on the consent form and the form, or the appropriate section of the form, should be scored through. In the case of publication, it is particularly important to make it clear to patients, when consent is originally obtained, that once the recording is in the public domain there is no opportunity for effective withdrawal of consent.

Further information

229. The above information is drawn from the GMC guidance: Making and using visual and audio recordings of patients (2011), which gives further detailed advice in the use of recordings when treating or assessing patients.

- HR1 – Health Records Management Procedure (Including Retention and Destruction Schedule
- IG17 – Procedure for the Non-Clinical Photography or Video / Audio Recording of Patients or Staff.

Telemedicine

231. Telemedicine should be viewed as a form of examination, and valid consent should be obtained in the same way as in any other examination, not just to the recording and exchange of information but to the process of telemedicine. The patient should understand that:

    - it is not the same as seeing a healthcare professional in a face-to-face meeting
    - the information/diagnosis received may be compromised by the technology
    - they have a right to decline review via telemedicine

    Healthcare professionals must abide by their IT Security Policy and Data Protection Policies in the handling of all images/recordings and data

11. Consent to Specific procedures

Consent to screening

232. Healthcare professionals must ensure that anyone considering whether to consent to screening can make a properly informed decision. As far as possible, they should ensure that screening would not be contrary to the individual's interest. Particular attention must be paid to ensuring that the information the patient wants or ought to have is identified and provided. Those taking consent should be careful to explain clearly:

- the purpose of the screening;
- the likelihood of positive/negative findings and possibility of false positive/negative results;
- whether there are any reasonable alternatives
- the uncertainties and material risks attached to the screening process;
- any significant medical, social or financial implications of screening for the particular condition or predisposition;
- follow up plans, including availability of counselling and support services.

233. If healthcare professionals are considering the possibility of screening adults and young people who do not have capacity to consent to the screening they must act in accordance with the MCA and ensure that decisions made are in the patient's best interests. In appropriate cases, account must be taken of the guidance issued by bodies such as the Advisory Committee on Genetic Testing.

Consent to Cosmetic Treatments (surgical and non-surgical)

234. From **1 June 2016** new GMC guidance for Doctors applies to both surgical (such as breast augmentation) and non-surgical (such as Botox) procedures. A link to this guidance can be found here: Guidance for doctors who offer cosmetic interventions (gmc-uk.org)

12. Seeking consent for genetic investigations (or investigations likely to reveal the diagnosis as being a genetic disorder)

235. Consent to genetic investigations is a particularly complex and controversial area.

Information and likely implications

236. When obtaining consent for investigations which may reveal genetic disorders, it is important that patients have been given full information about the likely implications of the test. Points to note about the types of result that might come from a diagnostic genetic investigation, and which should be understood by the person giving consent:

- a clear explanation of the patient's problems or features
- no relevant findings, even if the problem has a genetic cause
- a variant of uncertain significance (on chromosomal microarray or on the DNA sequencing of a gene, a panel of genes, the exome or the whole genome). It may become possible to clarify the interpretation of such a VUS at some point in the future, so a reinterpretation after a few years might be appropriate
- an incidental finding may emerge of no relevance to why the test was performed but still of some possible clinical importance to the patient and perhaps to other members of the family. A test may be performed to investigate neurodevelopmental difficulties, for example, but - whether or not the results explained those problems - it might find some other variant that indicates a serious risk of an inherited cancer or of cardiac disease or late-onset dementia etc.
- the result may be subject to reinterpretation in the future as our understanding of genetics is improving rapidly, one has to regard many results issued now as somewhat provisional.

237. If healthcare professionals are considering the possibility of performing investigations on adults and young people who do not have capacity to consent to the investigation, they must act in accordance with the MCA and ensure that they make decisions in the patient's best interests.

238. It is recommended that reference should be made to specialist guidelines such as guidance issued by the Joint Committee on Medical Genetics: BSGM - The British Society for Genetic Medicine

13. Withholding or withdrawing life – sustaining treatment

General

239. The GMC guidance Treatment and care towards the end of life: good practice in decision making (2010) provides detailed guidance on withdrawing and withholding life - sustaining treatment.

240. A competent patient should always be consulted when making a decision to withhold or withdraw life-sustaining treatment unless the healthcare professional forms a view that involvement will actually 'harm' the patient. Recent case law has underlined the extent of the duty of the healthcare professionals to consult a competent patient [11] or those with an interest in the welfare of the patient, where that patient lacks mental capacity to be involved in the decision [12].

241. Any valid and applicable ADRT is legally binding and must be respected unless a patient has subsequently made a Health and Welfare LPA giving the attorney authority to make decisions regarding the provision of life-sustaining treatment.

242. Where the patient lacks capacity to be involved in the decisions, and the patient has not made a Health and Welfare LPA giving an attorney appropriate authority, the healthcare professional must consult the patient's relatives, friends, or carers and other professionals involved in their care when making a best interests decision about the withholding or withdrawal of life-sustaining treatment. If there is no-one other than paid staff to consult with, an IMCA must be instructed. Where an urgent decision is required and a patient's representatives cannot be contacted, the reasons for this must be carefully recorded in the patient's medical notes. See reference in paragraphs 164 - 171 above.

243. There is an important distinction between withdrawing or withholding treatment which is of no clinical benefit to the patient or is not in the patient's best interests, and taking a deliberate action to end the patient's life. A deliberate action which is intended to cause death is unlawful. Equally, there is no lawful justification for continuing treatment which is not in a patient's best interests.

244. Once a decision has been reached to withhold or withdraw life-prolonging treatment, the basis of the decision and the details of any discussions with the patient and/or their representatives must be recorded in the medical notes. Decisions to withhold or withdraw life-prolonging treatment should be reviewed periodically and following any relevant change in a patient's circumstances.

11 *Tracey v Cambridge University Hospital NHS FoundationTrust & Ors*
12 *Elaine Winspear v City Hospitals Sunderland NHS Foundation Trust*

Prolonged disorder of consciousness

245. If the MCA and MCA Code of Practice and regulatory framework are observed correctly, there is agreement as to what is in the patient's best interests and a second independent clinical opinion is available which supports the best interests decision, life sustaining treatment (including CANH) can be withdrawn/withheld without the need to make an application to the court. For more detail see paragraphs 186 and 187 above.

246. Additional information is available from:

- Royal College of Physicians – Prolonged disorders of consciousness: national clinical guidelines - 2015
- BMA (2007) Withholding and withdrawing life-prolonging medical treatment: guidance for decision making, 3rd edition.
- GMC (2010) Treatment and care towards the end of life: good practice in decision making.
- An Interim Guidance document produced in December 2017 by the GMC, BMA and RCP entitled "Decisions to withdraw clinically-assisted nutrition and hydration (CANH) from patients in permanent vegetative state (PVS) or minimally conscious state (MCS) following sudden-onset profound brain injury".

14. Medical Treatment of Patients with a Mental Disorder

Commented [LR8]: This section needs to cross reference and be consistent with the policy for admission to patients under part II of the MHA

Basic principles

247. This chapter provides information regarding consent issues relating to the medical treatment of patients with a mental disorder. It should not be read in isolation from the rest of this policy, since the principles contained throughout this document apply to all patients from whom consent is sought, irrespective of whether or not they have a mental disorder. The chapter should be read in conjunction with MHLD 0026 - Policy for Admission, Receipt and Scrutiny of Statutory Documentation.pdf (sharepoint.com)

248. The principle of self-determination and autonomy of the individual, described in chapter 1 of this policy, applies equally to those who are suffering from mental disorder; a key distinction being that, in the circumstances authorised by the Mental Health Act 1983 (referred to as the MHA), treatment for a mental disorder may be given in the absence of the recipient's consent. Nevertheless, consensual treatment should always be sought in line with the principle of provision within the least restrictive context.

249. Part 4 of the MHA is concerned with consent to treatment. The reader should also refer to the MHA 1983 Code of Practice for Wales, 2016 generally and particularly chapters 24 and 25 for further information about consent and the Mental Health Act 1983.

250. Patients suffering from mental disorder, including those detained under the MHA are not necessarily incapable of giving valid consent and each patient's capacity to consent has to be judged individually in the light of the decision required and the patient's mental state at the time. Lack of capacity can be permanent or temporary and can also vary over time. Assessment of capacity should follow the principles described in the Mental Capacity Act 2005 (see chapter 8 of this policy).

251. The approved clinician in charge of the treatment has a duty to ensure that the patient is provided with sufficient information to enable him/her to understand:

- the nature, purpose, likely and intended effects of the treatment,
- their right to withdraw consent at any time, and
- how and when treatment can be given without their consent, including the legal authority for the treatment.

252. A record of the discussion at which consent is obtained or sought must be fully recorded in the health records.

253. Inpatients in Wales, whether detained or informal, and those subject to conditional discharge, a community treatment order, or guardianship are eligible for an independent mental health advocate (IMHA). All patients being considered for s57 type treatments (i.e. psychosurgery or implantation of hormones to reduce

male sex drive) and children under 16 years being considered for ECT are also eligible. The only exception is a patient detained in a place of safety under s135 or s136 of the MHA. Further information about the role of the IMHA may be found in chapter 6 of the MHA Code of Practice for Wales, 2016.

Medical treatment for mental disorder

254. Psychiatric in-patients may be classified into three groups when considering consent to treatment for their mental disorder:

- patients detained under the Mental Health Act 1983,
- informal patients who possess capacity to consent to treatment, and
- informal patients who lack capacity to consent to treatment.

Patients detained under the Mental Health Act 1983

Commented [LR9]: Presumably this is supposed to be a heading but it looks like it's just a repeated bullet point. Please consider reformatting

255. Where a patient is capable of giving consent and refuses, non-consensual treatment may only be given if it is for a mental disorder and the healthcare professional has the legal authority in accordance with the provisions of the MHA and the necessary certification requirements. Medical treatment includes nursing, psychological intervention and specialist mental health rehabilitation and rehabilitation and care the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations.

256. Medical treatment for mental disorder (except treatments under s57 i.e. psychosurgery and implantation of hormones to reduce male sexual drive) may be lawfully administered without the patient's consent provided:

- the patient is detained under the Mental Health Act 1983 (excluding patients detained under ss4 (4) (a), 5(2), 5(4), 35, 135, 136, 37(4)), and
- the proposed medical treatment falls within the provisions of
  - s58 (a second opinion is required for patients who are refusing or incapable of consenting after three months of treatment),
  - s62 (urgent treatment), or
  - s63 (treatment for the first three months of detention) of the MHA.

Informal patients who possess capacity to consent to treatment

257. Where informal patients possess the required capacity to give valid consent to medical treatment for mental disorder or to a plan of treatment, then their consent must be obtained. Where appropriate, this should be written consent. Where

informal patients with capacity refuse treatment for their mental disorder consideration may be given to detaining the patient under the provisions of the MHA.

Informal patients who lack the capacity to consent to treatment

258. An assessment of capacity should be undertaken in accordance with the MCA. If a patient is found to lack capacity to consent to treatment, then a determination of their best interests must be undertaken before any treatment is provided. In assessing someone's best interests it is essential to consult people who are close to the patient.

259. Section 5 of the Mental Capacity Act 2005 (MCA) provides that treatment may be given to a patient who lacks capacity to consent provided that it is in his or her best interests to do so. Section 6 of the MCA provides that a patient may only be restrained to give care or treatment if it is necessary to prevent harm and it is a proportionate response to the likelihood and severity of that harm.

260. If a patient who lacks capacity to consent to treatment appears to be objecting to treatment, then consideration should be given to detaining the patient under the MHA - *provided that it is in his/her best interests*.

Patients detained under the Mental Health Act 1983 requiring treatment for a physical disorder

261. Part IV of the MHA is concerned with medical treatment for mental disorder. The MHA cannot be used to enforce treatment for a physical disorder, which is unrelated to a mental disorder, where a patient refuses consent. For patients who lack capacity to consent to medical treatment for a physical illness the provisions of the MCA would be engaged.

262. The patient's mental disorder may affect their capacity to consent. This should be assessed as a priority in line with the MCA, as treatment for the physical disorder might proceed in the patient's best interests. However, it should not be assumed that the patient lacks capacity simply because they have a mental disorder.

263. Section 63 of the MHA may allow for the treatment of a physical disorder, without the patient's consent, where it is 'ancillary to the treatment of the mental disorder' for example:
- Nasogastric feeding a patient with anorexia nervosa (*Re KB (Adult)* (1994))
- Taking blood for patients on clozapine
- Treating self-inflicted wounds

264. The term 'medical treatment' in section 63 of the MHA refers to treatment which, taken as a whole, is calculated to alleviate or prevent a deterioration of the mental disorder from which the patient is suffering. This includes a range of acts ancillary to the core treatment including those which prevent the patient from harming herself or those which alleviate the symptoms of the disorder (*B v Croydon HA*

[1995])

265. If uncertainty exists as to a patient's capacity to consent to treatment, or whether the physical disorder may be treated as a symptom of the mental disorder, legal advice should be sought. See appendix C.

15. Consent to research and innovative treatment

Research

266. Any research undertaken within the Health Board must be registered with the Health Board Research & Development Office, from where additional advice can be obtained. All research and development must be approved before it can be commenced. Please refer to TM01 R&D SOP for Participant information sheets and informed consent and TM08 R&D SOP for Participant selection and recruitment. The latest version is available on the BCUHB website under Policies, procedures, guidelines and other written control document library for all staff, Research and Development Policies and key documents webpage Policies - Research and Development (sharepoint.com)

267. Consent to clinical trials is covered by the Medicines for Human Use Regulations 2004

268. The same legal principles apply when seeking consent from a patient for research purposes. GMC guidance states that patients 'should be told how the proposed treatment differs from usual methods, why it is being offered, and if there are any additional risks or uncertainties'.

269. Where the proposed treatment is of an experimental nature, but not part of a research trial, this fact must be clearly outlined to the patient along standard alternatives – including no treatment – during the consent process.

Patients who lack capacity to consent to being involved in research

270. There are strict rules within the MCA concerning the involvement of people who lack capacity in research (see MCA Code of Practice and Welsh Government's Guide to Consent for Examination and Treatment). In determining whether the patient should participate in the proposed research, the patient's wishes and feelings about being involved in research should be respected. It should be stressed that many research studies are non-therapeutic, i.e. they will not benefit the research participants personally. Carers or other persons who have an interest in the patient's welfare must be consulted. If there is no one who can be consulted, then a person who is unconnected with the research project must be appointed to advise on whether the patient should take part in the research. If at any time during the research it appears that the patient is upset or unhappy, it must cease immediately. Please adhere to the Health Board's Health Research Standard Operating Procedure - TM01.

271. Where a patient lacks capacity, experimental/innovative treatment cannot be given unless it is in their best interests. Where there is no alternative treatment available, it may be reasonable to consider an experimental treatment, with unknown risks and benefits, where treatment may benefit the patient.

Consent to research and innovative treatment in children

272. The legal approach to consent to therapeutic research in children is similar to any other proposed examination or treatment: the treatment must be in the child's best interests.

273. Health Board staff should contact the R&D Department for further advice on obtaining consent for children aged under 16 years. The approach will differ depending on whether the study is a clinical trial or not, and whether or not the proposed research will take place in an emergency setting.

Supplementary Guidance

16. Consent in obstetrics and gynaecology

Pregnant women

274. A pregnant woman with capacity may refuse any treatment, even if this would be detrimental to herself and/or her fetus(es). Any treatment involving the fetus will require maternal consent. However, it should be stressed that maternal refusal of treatment thought to benefit one or both parties is a rarity.

Caesarean birth (including refusal)

275. If a caesarean birth is required, the standard Consent Form 1 or approved BCUHB Procedure Specific Consent Form must be used. Women in labour can consent to a caesarean birth even if they have received sedation.

276. It is important to ensure that all pregnant women have a good understanding of the different ways in which they may give birth and the associated benefits and material risks. This will include information about the circumstances in which a caesarean birth will be offered. A pregnant woman with capacity may refuse a caesarean birth, even if "the consequence may be the death or serious handicap of the child she bears, or her own death" (Court of Appeal *Re MB*). In other words, a mentally competent woman in labour has the same right under common law to consent to or refuse consent to treatment as any other patient. United Kingdom law does not currently grant the fetus any legal rights, therefore a caesarean birth cannot be authorised by a Court against a competent woman's will and action cannot be taken in the best interests of the pregnant woman or the fetus. In this situation all advice given to the woman should be recorded in her notes. Unequivocal assurances should be obtained from the woman (and recorded in writing) that the refusal represents an informed decision: that is, that she understands the nature of and reasons for the proposed treatment and the risks and the likely prognosis involved in the decision to refuse or accept it. It is good practice to ask the woman to sign the written indication of her refusal. It is also good practice to involve another senior colleague to indicate that a body of senior medical opinion considers caesarean birth to be the most appropriate course and that the patient has refused consent for a caesarean birth.

277. If the woman is unwilling to sign a written indication of this refusal, this too should be recorded in the notes. Such a written indication is merely a record for evidential purposes. It should not be confused with or regarded as a disclaimer.

278. There have been a number of cases where doubts have arisen, for various reasons, as to a woman's capacity to make a valid decision about a caesarean birth. Temporary factors such as fear, shock, fatigue, pain or drugs may affect capacity. If there is reason to doubt capacity, support should be provided to help the woman make a decision. If that fails, a capacity assessment must be undertaken.

279. Where there is any doubt about a woman's capacity and/or where a refusal would lead to serious consequences for the pregnant woman or her unborn child, then legal advice should be obtained. If a pregnant woman refuses a caesarean birth (or any other intervention) and it has been demonstrated (in line with the Mental Capacity Act) that she lacks the capacity to make such a decision, an application to the CoP will be required to decide whether or not such treatment can be carried out. Healthcare professionals should seek advice from the Clinical Law and Ethics Advisors via:BCU.Consent@wales.nhs.uk. If they are unavailable, please contact the DoLS Team on BCU.DoLSAdmin@wales.nhs.uk. If they are unavailable and the matter is urgent, the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk. Out of hours, please contact Bronze on call via switchboard. In the case of *Re S*, the Court of Appeal laid down general principles that should be applied in future cases. If the mother lacks capacity, avoiding the fetus' death may be seen by the Court as being in the best interest of the mother.

280. Where a pregnant woman lacks capacity due to unconsciousness and so is incapable of giving consent, the caesarean birth may be carried out if it is in her best interests, unless a valid and applicable advance decision to refuse treatment exists. The most usual form of advance decision used by pregnant women is the birth plan. However, if there is reason to doubt the reliability of the advance decision (e.g. it might sensibly be thought not to apply to the circumstances which have arisen – see chapter 8 of this policy) then legal advice should be sought. See Appendix C.

Sterilisation

281. Men and women requesting sterilisation should be given information about alternative long-term reversible methods of contraception. This should include information on the risks, benefits and relative failure rates of each method. Non-operative methods of long-term contraception should have been specifically rejected by the patient before a decision is taken to proceed with sterilisation.

282. Both vasectomy and tubal occlusion should be discussed with all men and women requesting sterilisation. Women in particular should be informed that vasectomy carries a lower failure rate in terms of post-procedure pregnancy and there is less risk related to the procedure when compared with female sterilisation.

283. Patients should be told that the procedure is intended to be permanent, but should also be given the success rates of reversal procedures. They should be informed that reversal operations after sterilisation are not available on the NHS. Assisted reproductive techniques e.g. in vitro fertilisation (IVF) and intracytoplasmic sperm injection (ICSI) are not routinely provided by the NHS following sterilisation.

284. People requesting sterilisation should be informed that tubal occlusion and vasectomy can be unsuccessful and that pregnancies can occur several years after the procedure.

285. Written consent must be obtained for vasectomy, and the man should be advised to take other contraceptive precautions until there have been two consecutive negative semen analyses. It is important that the possibility of late failure is explained to the patient and his partner before vasectomy, so they can make informed decision about additional contraceptive methods.

286. Non therapeutic sterilisation of someone who lacks the capacity to give their consent must be referred to the Court of Protection. The individual's capacity and best interests must be thoroughly assessed in line with the Mental Capacity Act and legal advice should be sought at all times. (See chapter 8 and Appendix C).

Fertility

287. It is a legal requirement under the HFEA 1990, as amended, that consent to the storage and use of gametes must be given in writing after the patient has received such relevant information as is proper and had an opportunity to receive counselling. Where these requirements are not satisfied, it is unlawful to store or use the patient's gametes. Healthcare professionals should ensure that written consent to storage exists before retrieving gametes.

288. Outside specialist infertility practice, these requirements may be relevant to healthcare professionals whose patients are about to undergo treatment which may render them sterile (such as chemotherapy or radiotherapy) where a patient may wish to have gametes, or ovarian or testicular tissue, stored prior to the procedure. Healthcare professionals may also receive requests to remove gametes from a patient unable to give consent.

289. The HFEA 1990 as amended makes provision to address cases where the taking of gametes is in the patient's best interests but the patient is unable to give written consent or lacks capacity to consent to the storage of the gametes.

290. Further guidance is available from the Human Fertilisation and Embryology Authority.

Termination of pregnancy

291. The termination of a pregnancy may only take place with the informed consent of the pregnant woman. Prior to obtaining written consent, discussion must take place concerning the type of procedure (medical or surgical) and the risk of complications. Written information should be given to support verbal information. The husband or putative father's authority is not legally required.

292. If a woman opts for a medical termination of pregnancy then a realistic description should be given of the process, the number of visits necessary. It should be pointed out that there is a small risk of heavy bleeding at home before returning to hospital for the second part of the procedure, and that there is a high chance of miscarriage if the patient changes her mind between the first and second stages of the procedure.

293. If cervical ripening agents are to be used before surgical termination of pregnancy, the patient should understand that there is a high chance of miscarriage if she changes her mind before completing the procedure.

294. Prior to taking consent for termination of pregnancy, the senior doctor (Registrar or above) must sign Certificate A (Abortion Act 1967) to indicate that he / she is in agreement with the need for the termination. The woman will receive counselling in advance of the procedure and will then be scanned to assess gestational age. If the procedure is to be undertaken, Consent Form 1 must be used.

295. Clinicians are advised to seek legal advice (see Appendix C) where:

- a woman lacks the mental capacity to understand and appreciate the nature or consequences of a termination of her pregnancy; or
- a woman is in a state of continuous unconsciousness and there is no reasonable prospect that she will regain consciousness in time to request and to consent to the termination of her pregnancy
- a partner wishes to over-rule a decision to terminate a pregnancy

Histological examination and disposal of non-viable fetal products

296. Consent should always be obtained with regard to the histological examination and disposal of non-viable fetal products up to the age of 24 weeks' gestation. Please refer to policy **PTH/HIS/0045 Sensitive handling of non-viable pregnancy losses up to 23+6 weeks gestation -** POC policy v19.pdf (wales.nhs.uk) for detailed information on how to obtain consent.

17. Treatment in a Mental Health setting

S57 MHA: Treatment requiring capacity, consent and a second opinion

Commented [LR10]: As per previous comment

297. Section 57 treatments include surgical operations that destroy brain tissue or destroy the functioning of brain tissue, and the surgical implantation of hormones for the purpose of reducing male sex drive. S57 applies to all patients, whether or not they are subject to the MHA. The chapter should be read in conjunction with MHLD 0026 - Policy for Admission, Receipt and Scrutiny of Statutory Documentation.pdf (sharepoint.com)

298. Treatment under s57 can only be given if all three of the following requirements are met:

- the patient consents to the treatment,
- a second opinion appointed doctor (SOAD) and two other people appointed by Healthcare Inspectorate Wales (HIW) certify the patient has the capacity to consent to the treatment and has done so, and
- the SOAD also certifies that it is appropriate for the treatment to be given to the patient on form CO1.

S58 MHA: Treatment requiring consent or a second opinion

299. The approved clinician (AC) in charge of treatment must obtain the valid consent of any patient before the administration of medicine by any means after three months, unless such medicine is being administered under s62 (emergency treatment).

300. There can only be one 3 month period for s58 treatment in any continuous period the patient is subject to detention. This includes a patient detained under s2 which is immediately followed by detention under s3 and the patient is then discharged onto s17A (supervised community treatment) followed by the patient being recalled and having the Community Treatment Order (CTO) revoked and again discharged onto s17A.

301. When the patient has given valid consent to take s58 type treatment form CO2 must be completed by the AC in charge of the treatment. All medicines must be designated by their classes (as described in the BNF) rather than individually. Moreover, the doses may be entered as within BNF limits, but specific doses must be included when the BNF limit is being exceeded. Any new addition to the classes of drugs requires a Form CO2 to be completed by the AC in charge of the treatment. A contemporaneous entry must be made in the clinical record to document the discussion between the AC and the patient at which consent was given. A copy of the completed Form CO2 must be attached to the current prescription card.

302. The patient may at any time, subject to s62, withdraw consent before the completion of the treatment (see s60 MHA).

303. Where a detained patient withdraws consent or refuses consent to the proposed treatment with medication under s58 the AC must trigger the safeguards of a second opinion from a SOAD appointed by HIW. The same safeguard of a second opinion will apply to detained patients unable to consent to treatment under s58 of the Act.

304. It is the responsibility of the SOAD to arrange to examine the patient and consult a minimum of two 'statutory consultees' (i.e. one of who is a registered psychiatric nurse and the other who is someone who has been professionally involved in the medical treatment of the patient) prior to making a clinical decision about treatment.

305. The SOAD and the two statutory consultees must record the outcome of their assessment in the patient's clinical notes. The AC in charge of the treatment should inform the patient of the decision of the SOAD.

306. The SOAD, if he concurs with the AC's treatment plan, will complete the appropriate new Form CO3 authorising the proposed treatment plan.

307. In the case of medication, the SOAD's Form CO3 will specify the classes of drug/drugs dosage (mostly within BNF limits) and the route of administration. A copy of the Form CO3 must be attached to the current prescription card and the clinical records with the original to be sent to the MHA Administrator's Office.

S58A: Electroconvulsive Therapy (ECT)

308. Section 58A applies to ECT and medication administered as part of ECT. It applies to all detained patients and to all patients who are under 18 years whether or not they are a detained patient.

309. The written consent of all patients with capacity to consent to receiving ECT must be obtained, whether or not they are subject to s58A. A record of the discussion with the patient and of the steps taken to confirm that the patient has capacity to consent should be made.

310. Patients of all ages to be treated with ECT should be given written information before their treatment starts which helps them to understand and remember, both during and after the course of ECT, the advice given about its nature, purpose, and likely effects.

311. The key differences from s58 are that:

- ECT cannot be given to an individual who has the capacity to consent to that treatment but refuses to do so unless it is immediately necessary to save the patient's life or to prevent a serious deterioration in the patient's condition (s58A(1)(a) and (2) and s62(1)(a) and (1A) MHA),

- no patients under the age of 18 can be given ECT unless a SOAD has certified that the treatment is appropriate, and

- certification from SOAD is required.

S58A (3) Detained adult patients with capacity to consent to ECT

312. The AC in charge of treatment or a SOAD can certify on Form CO4 that the patient has attained the age of 18 and is capable of understanding the nature, purpose and likely effects of ECT and has consented to that treatment.

313. The original Form CO4 must be sent to the MHA administrator with a copy kept for the clinical record and one to go with the patient to the ECT department each time the patient is to receive the treatment. The patient may withdraw consent at any time. The certificate would not be valid if the patient subsequently lacks the capacity to make that decision during the course of treatment.

S58A (4) Detained or informal children and young people with capacity to consent to ECT

314. For children and young people ECT may be given if the patient has consented and a SOAD has certified, on Form CO5, in writing:

- that the patient is capable of understanding the nature, purpose and likely effects of the treatment and has consented to it; and

- that it is appropriate for the treatment to be given.

S58A (5) and (6) Patients who lack capacity to consent to ECT

315. Patients who lack capacity to consent to treatment may be given ECT if a SOAD has certified in writing:

- that the patient is not capable of understanding the nature, purpose and likely effects of the treatment; but

- that it is appropriate for the treatment to be given; and

- that giving the patient the treatment would not conflict with:

- an advance decision which the SOAD is satisfied is valid and applicable, in accordance with s25 of the MCA; or

- a decision made by a donee or deputy or by the Court of Protection.

316. The SOAD must complete form CO6.

317. The SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. One shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner. Furthermore, neither shall be the responsible clinician (if there is one) or the approved clinician in charge of the treatment in question.

S60 Withdrawal of consent

318. Patients treated in accordance with s57, s58 or s58A may withdraw their consent to that treatment at any time. Fresh consent for the implementing of procedures as required by those sections will then be required before further treatment can be carried out or reinstated, except as provided for under the urgent treatment provisions within s62.

319. Where the patient withdraws consent he or she should receive a clear explanation:

- of the likely consequences of not receiving the treatment;
- and in the case of s58 treatments that a second medical opinion under Part 4 of the Act may or will be sought, if applicable, in order to authorise treatment in the continuing absence of the patient's consent; and
- of the power of the approved clinician in charge of the treatment to begin or continue urgent treatment under s62, if applicable.

320. The patient's withdrawal of consent and explanations given to the patient in light of that withdrawal of consent must be clearly documented in the patient's case notes.

S62 Treatment not requiring consent

321. The consent of a patient subject to s56 i.e. most detained patients subject to the exceptions described in para 9(a) is not required for the administration of urgent treatment under s62. The forms of treatment are expected to include only those authorised under s58 and s58A. In urgent situations, such treatments can be administered without a second opinion. Whenever s58 or 58A type treatment is administered under s62, a simultaneous request must be made for a second opinion.

322. The same principle applies to a patient who has consented to take medication and then withdraws his consent after the three month period. HIW will be requested to arrange for the visit of a SOAD. Where the treatment is urgent, s62(2) may be used to continue with the treatment plan if the AC in charge of the treatment considers that discontinuance of the treatment or treatment under the plan would cause serious suffering to the patient.

323. There is no statutory prescribed form to record the use of treatment under s62,

but a local record form should be completed each time s62 is used to treat a patient.

S63 Treatment not requiring consent

324. Section 63 authorises medical treatment for mental disorder without consent and includes treatments that may alleviate the underlying causes of mental disorder, but not including treatments covered by s57, s58 or s58A, provided the treatment is given by or under the supervision of the AC in charge of treatment.

Advance Decisions to Refuse Treatment

325. A patient with a mental disorder is able to make a valid and applicable ADRT, as long as they have mental capacity at the time the advance decision is made. The fact that a patient was/is detained under the Mental Health Act when the ADRT advance decision was made does not render him/her incapable.

326. If a patient has made a valid and applicable ADRT but that treatment is for a mental disorder a healthcare professional may still give that treatment to the patient if he or she has authority to do so under Part 4 or 4A of the Mental Health Act 1983 and consent is not required. An ADRT can override the provisions in s57 of the Act, but not those contained in s58, s62 and s63. In respect of ECT (s58A), a valid and applicable ADRT would prevent a SOAD from issuing a certificate but would not necessarily prevent the AC in charge of the treatment from giving urgent ECT treatment as described in s62.

327. Chapter 8 of this document provides more information in relation to advance decisions.

PART 4A Treatment of patients on a Community Treatment Order (CTO) not recalled to hospital

328. The purpose of a community treatment order (CTO) is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm to the patient or others.

329. Only patients who are detained in hospital for treatment under s3 of the MHA or are unrestricted part 3 patients (i.e. s37 without a s41) can be considered for a CTO.

330. Patients not recalled to hospital include patients on a CTO who are in hospital if they have been admitted informally.

CTO Patients (aged over 16 years) with capacity to consent to treatment

331. Compulsory treatment cannot be given to a patient on a CTO who has not been recalled to hospital and who has capacity to consent or refuse treatment and is refusing. There are no exceptions to this rule, even in emergencies.

332. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto a CTO.

333. The Responsible Clinician completes form CO8 for s58 and s58a for patients with capacity to consent to treatment who are consenting to treatment.

334. A new CO8 form will need to be completed if there is a change of responsible clinician.

335. The Part 4A certification requirement does not apply if the treatment is immediately necessary and the patient has capacity to consent to it and does consent to it.

S64D Adult CTO patients lacking capacity to consent to treatment

336. A person is authorised to give medical treatment for mental disorder to a CTO patient who lacks capacity to consent to treatment if the following conditions are met:

- before giving the treatment, the person takes reasonable steps to establish whether the patient lacks capacity to consent to the treatment;
- when giving the treatment, he reasonably believes that the Supervised Community Treatment (SCT) Order patient lacks capacity;
- he has no reason to believe that the patient objects to be given the treatment; or he does have reasons to believe that the patient so objects, but it is not necessary to use force to give the treatment;
- he is the approved clinician in charge of the treatment, or the treatment is given under the direction of that clinician; and
- giving the treatment does not conflict with an advance decision which he is satisfied is valid and applicable, or a decision made by a done or deputy of the CoP.

337. A Part 4A certificate is not required for the first month for s58 type treatment after a patient's discharge onto supervised community treatment.

338. The Responsible Clinician must request a SOAD, who completes form CO7, if a patient lacks capacity to consent to s58 or s58A treatment.

339. Before giving a Part 4A certificate, the SOAD shall consult a minimum of two other persons who have been professionally concerned with the patient's medical treatment. Of those persons s/he shall consult:

- at least one shall be a person who is not a registered medical practitioner; and
- neither shall be the patient's responsible clinician or the person in charge of the treatment in question.

340. The Part 4A certification requirements do not apply if the treatment is given in accordance with s64G (emergency treatment in patients lacking capacity), or the treatment is immediately necessary and a donee or deputy or the Court of Protection consents to the treatment on the patient's behalf.

S64G Emergency treatment for CTO patients lacking capacity or competence

341. A practitioner is authorised to give emergency treatment to a patient who lacks capacity to consent to treatment, and who is subject to a CTO, if the following conditions are met:

- the practitioner reasonably believes that the patient lacks capacity to decide or is not competent to consent to it;
- the treatment is immediately necessary; and
- if it is necessary to use force against the patient in order to give the treatment; the treatment needs to be given to prevent harm to the patient; and the use of such force is a proportionate response to the likelihood of the patient suffering harm, and to the seriousness of that harm.

342. The responsible clinician will fill in the appropriate form.

What does 'immediately necessary' mean?

343. Treatment is immediately necessary if:

- It is immediately necessary to save the patient's life; or
- It is immediately necessary to prevent a serious deterioration of the patient's condition and is not irreversible; or
- It is immediately necessary to alleviate suffering by the patient and is not irreversible or hazardous; or

- It is immediately necessary, represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others and is not irreversible or hazardous.

344. However, ECT may only be given in an emergency if it is immediately necessary to save the patient's life or to prevent a serious deterioration of the patient's condition.

S64E Child CTO Patients (aged under 16)

345. Medical treatment may be given when there is authority to give it and the certificate requirements are met.

346. Certification is not needed for the first month after discharge onto the CTO or if it is immediately needed and the child is competent to consent to the treatment.

S64F Child CTO patients lacking competence to consent to treatment

347. A person is authorised to give medical treatment for mental disorder to a patient subject to a CTO under the age of 16 years if the following conditions are met:

- the person takes reasonable steps to establish whether the patient lacks competence to consent to the treatment;
- he reasonably believes that the child lacks competence to consent to the treatment;
- he has no reason to believe that the patient objects to being given the treatment, or he does have reason to believe that the patient so objects, but it is not necessary to use force to give the treatment; and
- he is the approved clinician in charge of the treatment; or the treatment is given under the direction of that clinician.

CTO patients recalled to hospital

348. CTO patients who are recalled to hospital are subject to s58 or s58A. Certification for s58 or s58A type of treatment is needed unless:

- less than one month has passed since the patient was discharged onto the CTO;
- the s58 or s58A treatment is already explicitly authorised for administration on recall by the Part 4A certificate; or

- if the AC in charge of the treatment considers that discontinuance will cause the patient serious suffering, he may continue with the treatment pending a fresh certificate.

349. For more detailed information regarding Community Treatment Orders, please refer to chapter 24 of the HA 1983 Code of Practice for Wales, 2016.

18. Training

350. Training on Consent to Treatment is available on ESR and is signposted via the Health Board's Consent Intranet Page - Consent training (sharepoint.com).

351. A generic rolling training programme on the principles and practical aspects of consent will be made available to all relevant Health Board staff.

352. All health care professionals joining the Health Board will be made aware of the policy on seeking consent and their responsibilities under the policy, during their induction. Quality and Safety Groups together with specialty clinical governance groups within the current structures are also responsible for raising awareness of the existence of this Policy. The Policy is also available on the above mentioned Intranet Page - Consent - Home (sharepoint.com).

353. Specific consent training will be provided for specific groups as the need arises.

Commented [LR11]: How do you record that staff are aware of the policy?

Commented [BT(-R12]: This responsibility would rest with the quality and safety groups and downstream governance/specialty groups within the current structures

Appendix A - Link to current consent forms in use in this organisation

All Wales Consent Forms: Patient Consent to Examination or Treatment - NHS Wales Shared Services Partnership

Appendix B - Useful contact / link details

- Clinical Law and Ethics advisors:
  BCU.Consent@wales.nhs.uk
- Claims Team via: 01248384603
  BCU.ClaimsWest@wales.nhs.uk
- Out of hours, please contact Bronze on call via switchboard
- Mental Capacity Act and DoLS Team
  BCU.DoLSAdmin@wales.nhs.uk or
  Tel: 03000 858745
- GC05 – Procedure for accessing legal advice
  GC05 - Procedure for accessing legal advice
- Appendix B - Pro forma for accessing legal advice
- Pathway for reporting Court Orders_ HSE Improvement _ Prohibition Notices and Judicial Review Notifications.pdf

Appendix C – How to obtain legal advice

If you need to obtain legal advice or apply for a court ruling in relation to a complex consent issue you should seek advice from the Clinical Law and Ethics Advisors via: BCU.Consent@wales.nhs.uk. If they are unavailable, please contact the DoLS Team via: BCU.DoLSAdmin@wales.nhs.uk. If they are unavailable and the matter is urgent, the Claims Team via: 01248384603 or BCU.ClaimsWest@wales.nhs.uk. Out of hours, please contact Bronze on call via switchboard

You should ensure that you have all the relevant information about the case to hand so that you can brief legal services / the solicitor appropriately. You should keep a clear record of the legal advice you have been given.

Where a decision is made to apply to a court, the lead clinician should, as soon as possible, inform the patient and his / her representative of the decision and of his or her right to be represented at the hearing. The patient's solicitor should be informed immediately and, if practicable, should have a proper opportunity to take instructions and apply for legal aid where necessary.

There may be occasions when the situation may be so urgent, and the consequences so desperate, that it is impractical to attempt to comply with these guidelines. Where delay may itself cause serious damage to the patient's health, or put their life at risk, then rigid compliance with these guidelines would be inappropriate.

The Court of Protection deals with serious decisions affecting personal welfare matters, including health care. Cases involving any of the following decisions should be regarded as serious medical treatment, and should be brought to the court:

a) cases involving organ or bone marrow donation by a patient who lacks capacity to consent;

b) cases involving non-therapeutic sterilisation of a patient who lacks capacity to consent;

c) where it is proposed to withdraw / withhold nutrition and hydration from a patient with a prolonged disorder of consciousness (PDOC) and for example, the case seems 'finely balanced', or where there are differences of opinion between treating clinicians, or between treating clinicians and patients' families as to whether ongoing treatment is in the patient's best interests or where a dispute has arisen and cannot be resolved. The term PDOC encompasses both permanent vegetative state (PVS) and minimally conscious state (MCS)

d) all other cases where there is dispute about whether a particular treatment will be in a patient's best interests (including cases involving ethical dilemmas in untested areas).

Appendix D - Assessing and documenting *Gillick* Competence in Under 16s

Assessment of *Gillick* competence should document the following[13]:

- The age of the child
- The intervention being offered
- The child's ability to understand that there is a choice and that choices have consequences, both risks and benefits
- The child's understanding of the nature and purpose of the proposed intervention
- The child's understanding of the proposed intervention's risks and side effects, both in the short and long term
- The child's understanding of any alternatives to the proposed intervention, and the risks and benefits attached to them
- The child's ability to weigh the information and arrive at a decision
- The child's willingness to make a choice (including the choice that someone else should make the decision)
- An estimate of the child's freedom from undue pressure

[13] Children and young people ethics toolkit (bma.org.uk)

Appendix E - About the consent form: information for patients

Before a doctor or other healthcare professional examines or treats you, they need your consent – in other words, your agreement. Sometimes you can simply tell them whether you agree with their suggestions. However, sometimes a written record of your decision is helpful – for example if your treatment involves sedation or general anaesthesia. In this case, you will then be asked to sign a consent form. If you later change your mind about having the treatment, you are entitled to withdraw consent – even after signing the form.

What should I know before deciding?

Healthcare professionals must ensure you know enough to enable you to decide about treatment. They will write information on the consent form and offer you a copy to keep (in either Welsh, English or both languages) as well as discussing the choices of treatment with you. Although they may well recommend a particular option, you do not have to accept that option. People's attitudes vary on things like the amount of risk or pain they are prepared to accept. That goes for the amount of information, too. The person who is treating you will encourage you to listen to all of the information about your treatment but if you would rather not know about certain aspects, discuss your worries with them.

Should I ask questions?

Healthcare professionals will encourage you to ask questions and you should always ask anything you want. As a reminder, you can write your questions down. The person you ask should do his or her best to answer, but if they don't know they should find someone else who is able to discuss your concerns. To support you and prompt questions, you might like to bring a friend or relative. Ask if you would like someone independent to speak up for you.

Is there anything I should tell people?

If there is any procedure or treatment you **don't** want, you should tell the people treating you. It is also important for them to know about anything that is particularly important to you and any illnesses or allergies which you may have or have suffered from in the past.

Who is treating me?

Amongst the healthcare professionals treating you may be a "doctor in training" – medically qualified, but now doing more specialist training. They range from recently qualified doctors to doctors almost ready to be consultants. They will only carry out procedures for which they have been appropriately trained. Someone senior will supervise – either in person accompanying a less experienced doctor in training or available to advise someone more experienced. Other healthcare professionals such as nurses and therapists may also provide you with treatment.

What about anaesthesia?

If your treatment involves general or regional anaesthesia (where more than a small part of your body is being anaesthetised), you will be given general information about it in advance. You will also have an opportunity to talk with the anaesthetist when he or she assesses your state of health shortly before treatment. For some procedures you will be invited to a pre-assessment clinic which will provide you with the chance to discuss things a few weeks earlier.

Will samples be taken?

Some kinds of operation involve removing a part of the body (such as a gall bladder or a tooth). You would always be told about this in advance. Other operations may mean taking samples as part of your care. These samples may be of blood or small sections of tissue, for example of an unexplained lump. Such samples may be further checked by other healthcare professionals to ensure the best possible standards. Again, you should be told in advance if samples are likely to be taken.

Sometimes samples taken during operations may also be used for teaching, research or public health monitoring in the future interests of all NHS patients. If a healthcare professional wishes to use your samples for research purposes they will ask for your written consent.

Students

One of the ways that student doctors, nurses or other healthcare professionals learn is by watching care or treatment being given. If the healthcare professional treating you would like a student to watch your examination or treatment, then they have to ask your permission first. If you are having sedation or anaesthetic during your treatment, then they need your written consent for a student to watch your procedure. This is why there is a section on the consent form for you to say whether or not you agree to students being present. If you are happy for the student to be present, they will be supervised by a qualified member of staff at all times. Your care will not be affected in any way if you decide that you prefer not to have students in the room during your procedure.

Advance decisions to refuse treatment

Some people chose to make "advance decisions” refusing certain care or treatment (sometimes referred to as “living wills” or “advance directives”). If you have made, or wish to make an advance decision refusing a treatment or procedure which may become necessary during the course of your care or treatment, then you must tell the healthcare professional caring for you. This will make sure that your decisions are followed, for example, whilst you are under anaesthetic. This is why there is a section on the consent form for you to say whether or not you have made a relevant advance decision.

Photographs, videos and audio recordings

As part of your treatment it is sometimes helpful for a photographic, video or audio recording to be made – for example to record changes to a skin lesson. You will

always be told if this is going to happen. The use of photographs and recordings is also extremely important for other NHS work, such as teaching or medical research. If the healthcare professional would like to take photographs, video or audio recordings, then you will be asked to sign a consent form giving your permission. The photograph / video / audio recording will be kept with your notes and will be held in confidence as part of your medical record. This means that it will normally be seen only by those involved in providing you with care or those who need to check the quality of care you have received, unless you have given permission for it to be used in other ways e.g. teaching, publication, research. We will not use the photograph / recording in a way that might allow you to be identified or recognised without your express permission.

What if things don't go as expected?

Amongst the 25,000 operations taking place every day, sometimes things don't go as they should. Although the doctor involved should inform you and your family, often the patient is the first to notice something amiss. If you are worried – for example about the after-effects of an operation continuing much longer than you were told to expect – tell a healthcare professional right away. Speak to your GP, or contact your clinic - the phone number should be on your appointment card, letter or consent form copy.

What do I need to know?

You should be aware of all of the significant risks (including important (material) risks to you), benefits and alternative treatments (including no treatment) so that you can make an informed decision

What are the key things to remember?

It's your decision! It is up to you to choose whether or not to consent to what is being proposed. Ask as many questions as you like, and remember to tell the team about anything that concerns you or about any medication, allergies or past history which might affect your general health.

Can I find out more about giving consent?

Betsi Cadwaladr University Health Board has a policy on patient consent to examination or treatment, which will be made available to you on request. The Welsh Government has also issued a *Guide to Consent for Examination or Treatment* which can be accessed at: Welsh Government Guide to Consent for Examination or Treatment (July 2017).pdf (wales.nhs.uk)

Questions to ask healthcare professionals

As well as giving you information healthcare professionals must listen and do their best to answer your questions. Before your next appointment, you can write some down.

You may want to ask questions about the **treatment itself**, for example:

- What are the main treatment options?
- What are the benefits of each of the options?
- What are the risks, if any, of each option?
- What are the success rates for different options (nationally, for this unit or for the surgeon)?
- Why do you think an operation (if suggested) is necessary?
- What are the risks if I decide to do nothing for the time being?
- How can I expect to feel after the procedure?
- When am I likely to be able to get back to work?

You may also want to ask questions about how the treatment might affect your future state of health or style of life, for example:

- Will I need long-term care?
- Will my mobility be affected?
- Will I still be able to drive?
- Will it affect the kind of work I do?
- Will it affect my personal/sexual relationships?
- Will I be able to take part in my favourite sport/exercises?
- Will I be able to follow my usual diet?

Health care professionals should welcome your views and discuss any issues so they can work in partnership with you for the best outcome.

Unacceptable behaviour

Our staff deserve the right to do their jobs without being verbally or physically abused. Most of our patients and visitors respect this right. Thank you for being one of them. We will work with the police to prosecute those who abuse our staff.

Complaints and compliments

We would like to hear your views about your experience of our services. Our aim is to provide you with the highest standards of care at all times, but we recognise that things can sometimes go wrong. If you have any concerns, speak to the ward sister or senior therapist who will be able to assist and, hopefully, resolve matters to your satisfaction. Where this is not successful, ask for our leaflet "Putting Things Right: Raising a concern about the NHS in Wales". This advises you how to make a formal complaint and the various stages of the procedure.

In making a complaint, advice and assistance is available to you from your local Community Health Council, which represents the interests of patients and the public in the NHS. The Community Health Councils are skilled in handling complaints. Their Complaints Advocates can provide a range of support during the process of your complaint.

The North Wales Community Health Council can be contacted as follows:

E-mail: complaints@waleschc.org.uk

Telephone:
Anglesey, Conwy and Gwynedd: 01248 679284
Denbighshire, Flintshire and Wrexham: 01978 356178

Data Protection Act (2018) & General Data Protection Regulation (GDPR) or any subsequent legislation having the same effect

Under current Data Protection Legislation, we are bound to protect the privacy of personal data. If you would like further information regarding what we do with your data please refer to the Health Board's Privacy Policy - Betsi Cadwaladr University Health Board (nhs.wales) Further details on how you can request access to your information can be found on our internet page:
http://www.wales.nhs.uk/sitesplus/861/page/45098

If you require further electronic copies of this publication please access the NHS Wales Shared Services internet page: All Wales Consent Forms: Patient Consent to Examination or Treatment - NHS Wales Shared Services Partnership.

Bwrdd Iechyd Prifysgol
Betsi Cadwaladr
University Health Board

IT FORMS

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

For:	**MD01 - Policy On Consent To Examination Or Treatment - (Based on the All Wales Model Policy)**
Date form completed:	7th September 2022

PARTS A: SCREENING and B:

KEY FINDINGS AND ACTIONS

Introduction:

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

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

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

Assessing Impact

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

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

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

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

Part A Form 1: Preparation

Please answer all questions

1.	What are you assessing i.e. what is the title of the document you are writing or the service review you are undertaking?	Policy on Consent to Examination or Treatment – MD01 (Based on the All Wales Model Policy)
2.	Provide a brief description, including the aims and objectives of what you are assessing.	The policy provides general guidance and support to clinical staff by describing the legal and practical requirements in relation to consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England, including: -the consent forms -when consent should be sought, including making the patient of all material risks, benefits and alternatives -provision of information -who is responsible for seeking consent -refusal of consent -treatment of children an d young people -patients who lack capacity to consent -use of tissues -consent to photography/video/audio recording -and various condition/subject specific consent issues e.g. medical treatment of the mentally ill / obstetrics & gynaecology issues etc.

Part A Form 1: Preparation

Please answer all questions

3.	Who is responsible for whatever you are assessing – i.e. who has the authority to agree or approve any changes you identify are necessary?	This is an All Wales Consent Policy. Within BCUHB, the Executive Medical Director is responsible for this policy. The policy will be agreed / approved by the Quality and Safety Executive Committee (QSE)
4.	Is the Policy related to, or influenced by, other Policies or areas of work?	This policy relates to the other policies, guidance, SOP's and so forth relevant to consent including: • Guidance on Mental Capacity Act 2005 including Deprivation of Liberty Safeguards • MD21 – Guidance – Production of Informed Procedure Specific Consent Forms, • Mental Health Act Policies • All Wales DNACPR Policy • Research Standard Operating Procedure - TM01 and TM08 • PTH/TR/601 - Refusal Of Blood And Blood Components Policy • SA01 - Safeguarding; Procedure for Safeguarding Adults at Risk • SCH017– Covert Administration of Medicines. • MHLD 0047 – Restraint Guidelines. • HR1 Health Records Management Procedure (Including Retention and Destruction Schedule), • IG17 Information Governance Procedure for the Non-Clinical Photography, Video / Audio Recordings of Patients or Staff. • ISU02 Policy – Written Information for Patients.
5.	Who are the key Stakeholders i.e. who will be affected by your document or proposals? Has a plan for engagement been agreed?	All clinical staff involved in taking consent to examination or treatment (implied, verbal or written consent) or with responsibility for checking consent forms before a procedure is undertaken (e.g. ward and theatre staff). This will include all locums, agency staff and staff with honorary contracts in addition to staff directly employed. All patients, their relatives and carers to whom this policy applies.

Part A Form 1: Preparation

Please answer all questions

6.	What might help or hinder the success of whatever you are doing, for example communication, training etc.?	This is an All Wales Policy which is already widely recognised. Health Board wide training is already in place in relation to the contents of the policy. Staff attitudes and understanding of the importance of capacity and consent issues may have an impact – training aims to clarify these issues for staff.
7.	Think about and capture the positive aspects of your policy that help to promote and advance equality by reducing inequality or disadvantage.	The policy itself helps to eliminate unlawful discrimination, harassment and victimisation by screening this policy. It promotes the Human Rights Act Articles – 2, 3, 5, 8 and 11. Those responsible for developing and assessing the policy have attended equality impact assessment training. Provision of translation services and that an adult with capacity may make a decision based on a religious belief or value system.

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

Please answer all questions

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

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

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

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

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

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

Please answer all questions

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

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

Please answer all questions

	NB: For all protected characteristics please ensure you consider issues around confidentiality, dignity and respect. **For the definitions of each characteristic please click here**					
	Yes	**No**	**(+ve)**	**(-ve)**		
Age	Yes		+		The policy differentiates between consent to treat children (aged under 16) young people (16 and 17 year olds) and consent to treat adults. An internet search found no evidence to suggest that any elements of the policy would have an adverse effect in relation to the protected characteristic of age. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.	N/A
Disability	Yes		+		Some disabilities are associated with impaired cognitive functioning and therefore with the possibility of impaired capacity. Patients who lack capacity to consent to the examination or treatment cannot give consent, but must be treated in their best interests. Form 4: Treatment in Best Interests is designed to ensure that the assessment of capacity and determination of best interests are compliant with the law and protective of the patient. An internet search found no evidence to suggest that any elements of the policy would have an adverse effect in relation to the protected characteristic of disability. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.	N/A

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

Please answer all questions

Gender Reassignment		No			No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.	N/A
Pregnancy and maternity	Yes		+		There are particular legal differences / issues that need to be considered in relation to consent of a pregnant people. These are highlighted within Chapter 16 of the policy to ensure that clinicians are aware.	N/A
Race	Yes		+		The policy contains a section which addresses provision for patients whose first language is not English. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.	N/A
Religion, belief and non-belief	Yes		+		The policy makes it clear that an adult with capacity may make a decision based on a religious belief or value system. Also, there is a whole section and a specific consent form relating to patients' who refuse blood or blood components (this is usually as a consequence of religious belief e.g. Jehovah's Witnesses). The policy makes reference to Procedure - Refusal of Blood and Blood components – PTH/TR/601. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.	N/A
Sex		No			No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact	N/A

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

Please answer all questions

Sexual orientation		No			No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact.	N/A
Marriage and civil Partnership (Marital status)		No			No evidence that this policy has any particular impact on this protected characteristic. The policy will comply with the guidance from the Next of kin | The Patients Association (patients-association.org.uk). EqIAs on policies from other NHS organisations indicated a neutral or positive impact	N/A
Socio Economic Disadvantage		No			No evidence that this policy has any particular impact on this protected characteristic. EqIAs on policies from other NHS organisations indicated a neutral or positive impact	N/A

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

Please answer all questions

Human Rights:

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

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

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

Please also consider these United Nations Conventions:

UN Convention on the Rights of the Child

UN Convention on the rights of people with disabilities.

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

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

Please answer all questions

Will people's Human Rights be impacted by what is being proposed? If so is it positive or negative? (tick as appropriate below)				Which Human Rights do you think are potentially affected	Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
Yes	**No**	**(+ve)**	**(-ve)**			
Yes		+			The policy is designed to address the fundamental human right that we have a legal and ethical right to determine what happens to our own bodies. For patients who lack capacity to consent for themselves, the policy is designed to ensure that the ascertainable wishes of patients lacking capacity are represented and considered by decision-makers. The policy complies with the Human Rights Act, particularly with regard to Articles 2, 3, 8, 9 and 11.	N/A

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

Please answer all questions

Welsh Language:

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

Welsh Language	Will people be impacted by what is being proposed? If so is it positive or negative? (tick appropriate below)				Reasons for your decision (including evidence that has led you to decide this)	How will you reduce or remove any negative Impacts that you have identified?
	Yes	No	(+ve)	(-ve)		
Opportunities for persons to use the Welsh language	Yes		+		The policy advises on use of the Welsh Language where appropriate. The All Wales Consent Forms have been designed to be bilingual, thus supporting the taking of consent in the welsh language. The Welsh copy of the forms must NOT be stored in the patients notes in place of the English copy, for patient safety reasons (all those checking the consent forms need to be able to read the content).	N/A
Treating the Welsh language no less favourably than the		No			In line with the Welsh Language Standards, the language preference of the patient must be offered, established, recorded, acted upon and relayed to others within the Health Board. Welsh speaking healthcare professionals should ideally obtain consent from patients whose preferred language is Welsh. If the relevant healthcare professional is not Welsh speaking, consent should be obtained with the support of Welsh speaking colleagues or simultaneous translation.	

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

Please answer all questions

English language						

Part A Form 4: Record of Engagement and Consultation

Please answer all questions

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

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

What steps have you taken to engage and consult with people who share protected characteristics and how have you done this? Consider engagement and participatory methods. *for further direction on how to complete this section please click here training vid p13-18)*	This is an All Wales Model Policy
Have any themes emerged? Describe them here.	*No*
If yes to above, how have their views influenced your work/guided your policy/proposal, or changed your recommendations?	*No specific changes. The majority of equality and human rights considerations have been considered at a national level as part of the all Wales Group.*

For further information and help, please contact the Corporate Engagement Team: BCU.GetInvolved@wales.nhs.uk

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

1. What has been assessed? (Copy from Form 1) *for further direction on how to complete this section please click here training vid p13-18)*	**POLICY ON CONSENT TO EXAMINATION OR TREATMENT** **(Based on the All Wales Model Policy)**

2. Brief Aims and Objectives: (Copy from Form 1)	The policy provides general guidance and support to clinical staff by describing the legal and practical requirements in relation to consent to examination and treatment in line with current legal and regulatory frameworks in Wales and England, including: -the consent forms -when consent should be sought, including making the patient of all material risks, benefits and alternatives -provision of information -who is responsible for seeking consent -refusal of consent -treatment of children an d young people -patients who lack capacity to consent -use of tissues -consent to photography/video/audio recording -and various condition/subject specific consent issues e.g. medical treatment of the mentally ill / obstetrics & gynaecology issues etc.

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

From your assessment findings (Forms 2 and 3):

3a. Could any of the protected groups be negatively affected by your policy or proposal? **Guidance: This is as indicated on form 2 and 3**	Yes	No x
3b. Could the impact of your policy or proposal be discriminatory under equality legislation? **Guidance: If you have completed this form correctly and reduced or mitigated any obstacles, you should be able to answer 'No' to this question.**	Yes	No x
3c. Is your policy or proposal of high significance? **For example, does it mean changes across the whole population or Health Board, or only small numbers in one particular area?** High significance may mean: - The policy requires approval by the Health Board or subcommittee of - The policy involves using additional resources or removing resources. - Is it about a new service or closing of a service? - Are jobs potentially affected? - Does the decision cover the whole of North Wales	Yes x	No

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

- Decisions of a strategic nature: In general, strategic decisions will be those which effect how the relevant public body fulfils its intended statutory purpose (its functions in regards to the set of powers and duties that it uses to perform its remit) over a significant period of time and will not include routine 'day to day' decisions. GUIDANCE: If you have identified that your policy is of high significance and you have not fully removed all identified negative impacts, you may wish to consider sending your EqIA to the Equality Impact Assessment Scrutiny Group via the Equalities Team/			
4. Did your assessment findings on Forms 2 & 3, coupled with your answers to the 3 questions above indicate that you need to proceed to a Full Impact Assessment?	Yes	No x	
	The policy is considered of high importance in relation to equality, diversity and human rights. The policy has been assessed as having an overall positive impact on the protected characteristics as the effect of the policy is to help safeguard the rights of patients giving or refusing consent, and will help to ensure they are provided with enough information to support decision making and to ensure that their views are heard and considered. The policy is compliant with the relevant legislation as summarised below The policy adopts the format and any additional information and guidance contained in the new All Wales Model Policy for Consent to Examination or Treatment.		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Impact in light of above changes has been assessed as neutral or positive in that the policy aims remain consistent and related to helping safeguard the rights of patients giving or refusing consent.	
5. If you answered 'no' above, are there any issues to be addressed e.g. reducing any identified minor negative impact?	Yes	x
	No remaining issues.	
6. Are monitoring arrangements in place so that you can measure what actually happens after you implement your policy or proposal?	Yes x	No
	How is it being monitored?	Any complaints, claims or incidents received in relation to equality, diversity and human rights following implementation of the policy will be addressed on an individual basis and appropriate action taken.
	Who is responsible?	Relevant clinical specialty Consent and Capacity Strategic Working Group
	What information is being used?	Relevant complaints and incidents are compiled into reports for scrutiny by the Consent and Capacity Strategic Working Group. Relevant claims are also highlighted to this Group. There is a Peer review of consent which forms part of the Tier 2 BCUHB annual audit plan.
	When will the EqIA be reviewed?	When this policy requires its next corporate approval

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

7. Where will your policy or proposal be forwarded for approval?	*Consent and Capacity Strategic Working Group* *CEG* *QSE*

8. Names of all parties involved in undertaking this Equality Impact Assessment – **please note EqIA should be undertaken as a group activity** Senior sign off prior to committee approval:	Name	Title/Role
	Manon Gwilym	Clinical Law and Ethics – Legal Advisor
	Dr Ben Thomas	Assistant Medical Director – Clinical Law and Ethics
Please Note: The Action Plan below forms an integral part of this Outcome Report		

Action Plan

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

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

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
1. If the assessment indicates significant potential negative impact such that you cannot proceed, please give reasons and any alternative action(s) agreed:	No indication of negative impact		
2. What changes are you proposing to make to your policy or proposal as a result of the EqIA?	*No specific changes. The majority of equality and human rights considerations have been considered at a national level as part of the all Wales Group.*		
3a. Where negative impacts on certain groups have been identified, what actions are you taking or are proposed to reduce these impacts? Are these already in place?	*No specific changes. The majority of equality and human rights considerations have been considered at a national level as part of the all Wales Group.*		

Part B Form 5: Summary of Key Findings and Actions

Please answer all questions

	Proposed Actions **Please document all actions to be taken as a result of this impact assessment here. Be specific and use SMART actions. Please ensure these are built in to the policy, strategy, project or service change.**	Who is responsible for this action?	When will this be done by?
3b. Where negative impacts on certain groups have been identified, and you are proceeding without reducing them, describe here why you believe this is justified.	N/A		
4. Provide details of any actions taken or planned to advance equality of opportunity as a result of this assessment.	N/A		

Teitl adroddiad: ***Report title:***	Mental Health Outcomes and Improvements
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023
Crynodeb Gweithredol: ***Executive Summary:***	This paper is to update the Committee on the progress to date with implementing the improvement plan for Mental Health and Learning Disabilities (MHLD) and, as a sub part of this improvement, the improvement actions arising from the Health and Saftey Executive (HSE) Notice of Contravention (NOC) received in May 2022.
Argymhellion: ***Recommendations:***	The Committee is asked to: • Note the contents of this report in relation to Mental Health Service improvement. . • Acknowledge the significant challenge to the division of staffing levels and staffing pressures which could further impact the delivery the improvement plan. • Note the outstanding actions in progress within the HSE NOC action plan, together with the mitigations the division are putting in place; and note that, only partial assurance of meeting the requirements of the Notice of Contravention can be provided at this time.
Arweinydd Gweithredol: ***Executive Lead:***	Teresa Owen, Executive Director of Public Health
Awdur yr Adroddiad: ***Report Author:***	Mike Smith, Divisional Improvement Lead, MHLD Division. Iain Wilkie, Divisional Director MHLD Division

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):***	The strategic implications of the Divisional Improvement Plan and alignment of work streams relate 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. Potential contravention of health and safety legislation, with a notice of contravention formally received in May 2022 from the Health and Safety Executive to 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?***	EQIA impacts are considered in any of the necessary policy changes and adaptations.
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?***	SEIA impacts are considered in any of the necessary policy changes and adaptations.

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)***	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. This paper relates to two tier 1 risks 3929 (risk to patient safety from ligature) & 4443 (risk of prosecution from the HSE)
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	The financial impacts of meeting the Notice of Contravention are ongoing and are being collated within the division. They are not fully identified at this stage.
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are significant recruitment issues impacting upon the short and medium term delivery of the improvement plant and the NOC actions, and these could potentially impact upon the divisions delivery of the improvement plan outlined in this paper
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.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	Significant risk of avoidable harm to patients and staff, due to a failure by the Health Board provide safe systems of delivery and work in accordance with the Health and Safety at Work Act 1974 and associated legislation. 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)***	Not applicable

Camau Nesaf:
Gweithredu argymhellion

Next Steps:

The MHLD improvement plan - phase 1, next steps are;

- To further refine and assure data sources which inform the outcome measures of the plan, to further maintain alignment to improvement approaches in the Board by linking with the Ysbyty Glan Clwyd improvement plan and the "Pan BCU programmes alignment" work.

- To develop the strategic aims and key actions of the improvement plan accross the 3 phases as a visual tool (dashboard) to inform the staff engagement.
- To develop the wider engagement plan for the improvement and transformaton plan within MHLD including establishing “safe spaces” for sharing and discussing and engaging with the improvements for all staff in the complex scope of delivery of mental health, learning disability and specialist services accross the whole of the Health Board.

Divisional Senior Leadership has requested and is currently undertaking a deeper exploration of its vacancies in order to better understand the potential causes and impact of staffing shortages /vacancies. The principles of ensuring staff are in place to deliver safe levels of care, reviewing practice, investing in skills development to deliver the transformations and constantly reviewing the process for workforce design, remain the guiding principles of the Mental Health Senior Leadership Team.

In terms of the **NOC activity**, It is proposed that a further update to this Committee will be required to provide further and fuller assurance on delivery of the actions to meet the requirements of the Notice of Contravention.

The Health and Safety Executive Notice of Contravention group will continue to provide the assurance of delivery of the actions arising from the NOC.

List of Appendices:

- Appendix 1 – Mental Health Outcomes and Improvements (main report).
- Appendix 2 – Outstanding Actions MHLD

Mental Health Outcomes and Improvements

Prepared for the Quality, Safety & Experience Committee, 20/01/2023

Brief background

This committee has been presented previously with the MHLD improvement plan which was developed with the improvement team and partners in 2022, and an update provided in November 2022.

There is a strong underpinning thematic approach throughout the improvement journey, on the fundamentals of care, improving safety, leadership and cultural change, built upon the "foundation elements" such as the workforce, estate and digital enablers. This was all informed by the numerous prior issues and reports touching Mental Health and Learning disabilities as described in the origins of the improvement plan.

This paper provides a further update on the improvement plan activity and we have we have provided detail on the Health and Safety Executive (HSE) Notice of Contravention (NOC) improvement activity – which is a divisional priority area of work.

Progressing the improvement plan

The improvement journey (phase one) Q2 – Q4 (2022-23) is an '**improving**' phase, and the division is actively preparing for phase two. Phase two is an '**achieving**' phase, which will span Quarters 1 – 4 (23/24), and we are aiming for a '**transformational'** phase in 24/25.

Further to the detailed work on developing the improvement plan between July and December 2022 the has now invested in an overarching improvement project lead to support the overall improvement activity and link with the wider Board improvements portfolio of work. (Mike Smith, former interim Director of Nursing for the Division). Close links are in place with the Ysbyty Glan Clwyd Transformation activity, and there are ongoing discussions with the BCUHB Transformation team.

The initial focus of the overall improvement project lead, since December 2022, has been to add capacity and focus to meet the requirements of the HSE NOC improvements and the 19 outstanding actions in progress, as an urgent priority. This is, of course, only one part of the overall Divisional improvement plan.

There has been considerable action to progress the MHLD divisional improvement plan overall since the November 2022 presentation to the committee.

There is workshop in late January 2023 to discuss "Operational teams and pan BCU programmes alignment" arranged by the Health Board's improvement team, which the division will participate and engage in.

The division is pleased to report that it has appointed David Patel to its vacant improvement lead role in December 2022, and he will contribute to the divisional improvement plan implementation.
The division continues to develop the evidence in the 'evidence bank' around accomplishments and outcomes, and is further developing a more visual dashboard approach to this evidence collection. This work is aimed to be completed by April 2023. This is learning from the Ysbyty Glan Clwyd Improvement team. We aim for a display that depicts the importance and contribution of small efforts and changes that everyone makes as 'cogs' in

the larger improvement process and the visual performance dashboard of the improvement KPI's demonstrating and communicating the "dials" . These will be displayed in the "safe spaces rooms" that we propose to establish in each of the three areas of operational delivery in Mental Health and one in the regional specialist services which include Learning Disability services, substance misuse, Neuro-development, rehabilitation and forensic services.

The winter pressures and "critical incidents" in the Board as well as the preparations for and impact of industrial action in December 2022 and January 2023 have and are likely to impact on the delivery of the improvement actions and both data collection and reporting.

There are six work streams within the improvement plan:

1. Fundamentals of care.
2. Leadership Empowerment, culture and organisational development.
3. Safe, effective care.
4. Individual and timely care.
5. Environment, resource and workforce.
6. Strategy, Audit, outcomes and assurance.

The area of safe effective care has been most progressed as a patient safety priority in this current period, with the focus on the NOC improvement delivery. The suite of outcome measures have been agreed and the data sources are being confirmed to collect evidence. The outcomes will be reviewed further to ensure alignment with the national outcomes framework which we await. These measures will report into the improvement plan reporting updates monthly. On testing the measures there has been issues of data submission, accuracy, testing and reliability, the work to amend this is in progress.

Key outcomes in phase 1 of the Improvement Plan to date

The division is aligned to and working closely to the Health Board's improvement approach and is applying Institute for Healthcare Improvement (I.H.I) methodology, whilst awaiting confirmation of the formal IHI package of support for MHLD.

The divisions "Targeted Improvement" (TI) activity is also progressing, and both the outcomes and evidence are collated and reported as necessary through the TI process.

Capacity has been added to the MHLD improvement team and the external project managers that have been supporting the division have ended their roles in December 2022. Each project manager completed a relevant end of project update.
There is a single overall plan within MHLD now bringing together the improvement and transformation, and this includes the Targeted Intervention process.

The ward accreditation process has been re-energised and is now delivering improvements. Two accreditation review visits are now undertaken each week and the division has appointed a practice development nurse lead for ward accreditation improvement.

Smoke free sites status was achieved (on target) from the 1st September 2022. This has been a considerable improvement piece of work for the division. It has provided learning for the division.

The new 111+2 service development is on target to deliver as planned with a planned impact of transforming access to Mental Health Services, contact and advice. Staff recruitment is now advanced for this project. The plan is to go live with a "soft launch on Monday 16th January 2023.

The Mental Health pathways development work (including "crisis care") is advance and this reports to the Divisional Clinical Strategy group.
The new 'Just recruitment' (Just R) plan has progressed, and has resulted in 32 applications to the MHLD division at the end November 2022.

A Mental Health ward estates safety report was both commissioned and completed in Q3 2022/23. This was undertaken by an external company.

Benefits realisation measures are in place as reported in November by the MHLD Divisional Senior Leadership Team 2022

The MHLD operating model has been reviewed and aligned to the IHC leadership model. This was presented to the Executive Team, and then the Health Board Leadership Team in October 2022.

Key Performance Indicators (KPI) for the improvement plan have been developed and agreed by the MHLD Senior Leadership Team with the support of the Health Board's improvement team (these are available for sharing with QSE members as required).

The MHLD improvement team are now (Q4) working on data source supply and robustness by March 2023, in order to improve the reliability of the KPI reporting. Some areas, reporting so far, show significant performance improvements such as divisional performance, and workforce e.g. PADR rates. This is notably where data sources are longer established, owned and tested. Accessing reliable data in some other areas of the outcome measures and KPIs have been challenging, often requiring manual collection and analysis. The project team are now working to turn the KPIs into a visual dashboard to help engage staff and develop ownership within its engagement work with divisional staff at all levels.

In the partnership space, the Together for Mental Health "Do well" workshops were held in September and October 2022. Over 180 colleagues attended from partner and stakeholder organisations. The strategy is now being developed, and an update will be provided to the Partnership Board on Friday 13th January 2022.

Delivery risks for the improvement plan

The division reflect on current delivery risks for its improvement agenda:

- Staff fatigue, winter pressures, industrial disputes and wider Health Board pressures reflected in "critical incidents", are a potential threat to the delivery plan. The timing of the "Safer Spaces staff engagement" activity on the improvement plan and the launch of the visual dashboard is being considered in this context the current target is March 2023.

- Progressing the data availability testing, and Information Technology (IT) elements as an enabler, is in itself a significant piece of work. This has been challenging in Q3 2022/23.

- The recruitment of certain groups of staff remains an issue as shown below with an overall worsening staffing position in Q3 2022/23.

- Our paper based and basic project management processes introduce potential fallibilities.

The above risks are being addressed as project risks, and are reported through the MHLD governance arrangements.

The MHLD division has robust and regular data on workforce/vacancies/recruitment activity (*see Table 1 below for KPI data extract from the divisional improvement plan*). There is

improvement in the outcomes for PADR/mandatory training, healthcare assistant (HCA) recruitment and administrative and clerical recruitment. However, and when compared to the benchmark in March 2022, the data for December 2022 shows significant deterioration for both Registered Nurse and Medical vacancies.

The division is pleased to report it has appointed to its vacant head of strategy and Partnerships role, Ms Vicky Jones. This added capacity will now enable the division to further develop the logic model to demonstrate how our improvement actions move us forward on the high level outcomes, which will further feed into the "cogs and wheels" engagement both within and outwith the division.

Table 1: KPI data extract

ENVIRONMENT, RESOURCE, WORKFORCE (Strategic Lead: Head of P&P/HoW)				
Understanding Roles, Capability - Skills, Knowledge & Practice				
	Data Source	**Data Source**	**Data Source**	**Data Source**
Vacancies	325.61	TBC	16	393.24
Leavers	9.04 WTE	TBC	9.52%	19.76 WTE
Sickness absence	8.67%	TBC	16	8.76%
PADR compliance increase from 78% to 85%	80.90%	TBC	78.00%	82%
Mandatory Training, Level 1 and Level 2 compliance to increase from 80.9% to 85%, relevant to post	78.80%	TBC	85.00%	90.11%
Managing daily caseload and staffing incl. rostering				
Number of Nursing vacancies	141.35 WTE 43%	TBC		177.25 WTE 45%
Number of HCA vacancies	141.35 WTE 43%	TBC		65.79 WTE 16%
Number of Admin & Clerical Vacancies	36.36 WTE 11%	TBC		41.50 WTE 10%
Number of Medical vacancies	50.09 WTE 15%	TBC		54.74 WTE 13%

Actions to meet the requirements of the Notice of Contravention improvements

The Notice of Contravention received from the Health and safety Executive in May 2022 outlined 3 breaches, relating to safety arising following the sad death by suspended ligature of a patient in the Hergest unit. The improvements specified in these 3 areas of breach, were further integrated as a sub part of the improvement activity of the division. There were 79 specific improvement actions developed by the NOC group, to address the breaches and improve patient safety, 61 of which have been completed as of December 2022 This paper informs the committee of the scope and progress to date of addressing the 18 outstanding actions.

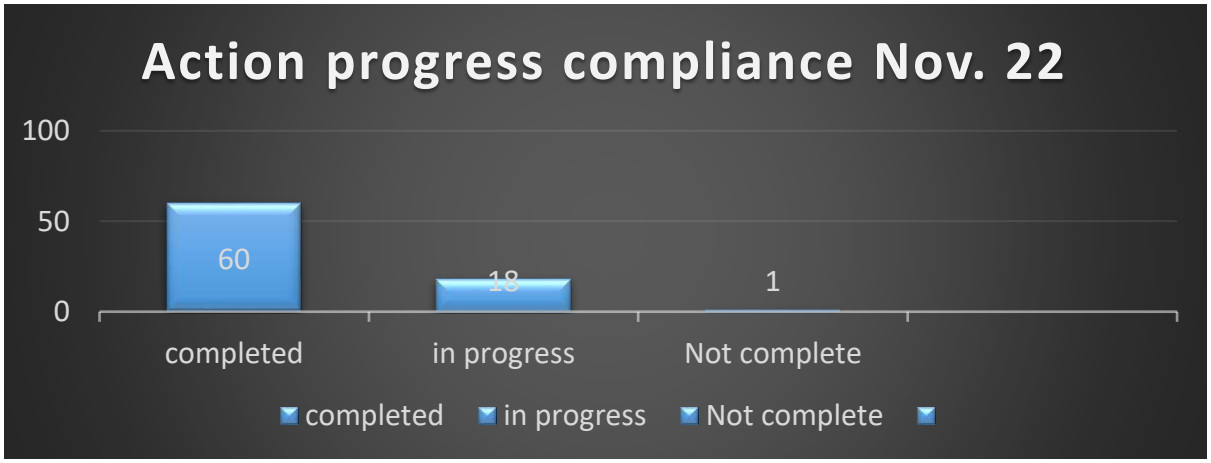
Because of the importance and risks associated with the Health and Safety Notice of Contravention (NOC) this improvement work has been a priority for the division throughout December 2022. There is an established NOC group, and the Senior Responsible Officer (SRO) is the Divisional Director of Mental Health and Learning Disabilities. The group meets weekly and this reports to the Divisional Senior Leadership Team weekly. There is also formal reporting on progress to the Divisional QSE, and the monthly Mental Health Summits.

The division intends to clearly meet the requirements to remedy the contraventions, for the whole MHLD division and not just for the Hergest Unit. Upon receiving the detail of the NOC, together with the independent investigation report of the specific incident the breaches pertain to (that had in itself recommendations for improvement), the division identified 79 actions it needs to complete. These 79 actions will improve patient safety from suspended ligatures.

Performance on NOC improvements

As of December 2022, of the 79 actions, 61 have been accomplished (although there are, and will be issues of ongoing embedding and maintenance of the assurances, as reported later). 18 actions are in progress and expected to be completed on target or imminently. All 18 are currently rated as Amber in the action tracker by the NOC group. One action (to introduce digital patient records) is not expected to be complete by its 2023 timescale because of its complexity and interdependency, and therefore is rated red.

Chart 1



A number of divisional policies (7) have had to be reviewed and consulted upon as a result of the contraventions and these are all complete or in process of ratification as detailed in the below table (*Table 2*). This process is material in the action update, as some of the outstanding actions are stage dependant, and require the policy to be changed before actions such as training and embedding can be fully completed.

Table 2: Policy position (NOC related)

Review and consultation	For approval at Divisional Policy Group	For approval at Divisional QSE	For approval at BCU PSQG	For approval at BCU QSE	Ratified
	MHLD 0056 Ligature & Anchor Point Risk Reduction Procedure for Mental Health Learning Disability Services MHLD 0013 Searching patients and their property		MHLD 0001 Acute Care Operating Framework MHLD 0043 Restricted items Policy	MHLD AC002 Therapeutic Engagement and Observation Policy	MHLD CPG 002 Supervision Guidance (published online) Nurse in Charge SOP (awaiting upload)

Outstanding actions

The full list of outstanding actions is appended to this report with the relevant target date. (Appendix 2).

18 of the outstanding actions are in progress, **11** of this number have exceeded their target date for completion (by 1-2 months) but are expected to be accomplished within Q4. Some of these are stage dependent as per the above table. For example some polices are overdue and some actions are related to longitudinal issues i.e. Quality and safety audits. **7** have not yet reached their target date

One action is not expected to be completed by its target date of October 2023. This relates to the digital patient record introduction and is because of the complexity and interdependencies of such an action. However the digital strategy of the Board is progressing, and the division now has a digital lead in post.

The outstanding actions have been themed: 7 are primarily concerned with training, 7 with audit and assurance, 3 about sharing learning and 2 “others”.

Training and audit have been impacted significantly by the availability of staffing. For example, the achievement of compliance with the Wales Applied Risk Reduction Network (WARRN) training is given as an example below, given its significance, with further details on the remedial actions and mitigations.

WARRN training

WARRN is the all Wales Applied Risk Research Network approach to coproducing and constructing risk formulations, and then clearly documenting the decisions/judgements in a person’s Care plan. WARRN has not previously been a mandatory requirement for staff and compliance in the division has not been included in the divisions’ performance analysis or reporting.

The agreed action is to achieve a level of 86% mandatory compliance with WARRN training (for registered health professionals in the division).

WARRN training has been the primary approach in the division, to risk assessment and formulation since 2010. There has been very little investment of resource or dedicated administrative support to deliver this. WARRN training was suspended during Covid, and training only recommenced in 2022, following guidance on training across Wales. A paper was shared with the Divisional Senior Leadership Team (DSLT) in June 2022. This recommended WARRN training should be seen as mandatory and this was supported. This supported the process of recording WARRN compliance in ESR, in order that performance can be captured and reported.

The division has identified which roles include this mandatory label. As a result, the division has manually established that 917 roles have this requirement i.e. applies (for all registered MH professionals). Clearly in this group there are other training frameworks and competing professional expectations e.g. medicine and psychology training, that also have to be also supported.

The division has 16 trainers for WARRN. Only one of these individuals has part time dedicated capacity to WARRN training as part of their role (this is the clinical risk lead). The remainder have other clinical roles). Many of these individuals are senior clinical nurses. Their ability to release these individuals, as trainers, even within the locality they work within has been an issue for the division given the operating context and pressures. Indeed four trainers are

currently unable to train until April 2023, due to work pressures and one individual has been longer term sick.

WARRN training has been completed for 512 of the 917 (or 56%) staff, and a further training of 70+ people (on top of this number) has been completed very recently however the data has not been manually recorded with position numbers on ESR. ESR has had to be adapted by the corporate team to reflect the new mandatory status. This is in process and is essential to allow accurate recording and assurance.

To increase training capacity the division supported nine people (in December 2022), to attend a specific train the trainer's course (2 days training) in South Wales followed by supervised training back in BCUHB. Of the nine individuals identified, three had to withdraw in the weeks before the course, and this reduced team attendance and were not able to be replaced on the course. Only three people actually completed the training, two individuals were Covid positive in the days before the training and one had to withdraw for personal reasons. These three individuals are now preparing for the increased training in 22-23, and other work is ongoing to support others who are operationally committed to be available through 22-23.

It is worth noting that the overall divisional compliance with mandatory training is, and has been, good achieving 84% overall in November 2022.

Next steps

The division has planned to specifically focus (through January 2023) on the compliance of all staff within the Hergest unit where the breach occurred, with WARRN training as a priority. Only 12 staff as of January 2023 now need training to achieve 100% compliance with the requirements of the notice of contravention in Hergest. This will be achieved through bespoke training in the unit, together with supporting planned bank and agency cover for staff replacement to ensure the attendance with the training as required (a major cause of non-compliance in Q3). This plan is in place and being supported and enacted in the Hergest and divisional teams, and 100% compliance is expected by the end of February 2023 within the Hergest unit.

Assurance of delivery, monitoring and evidencing of actions and accomplishments

The NOC group ensures delivery of the actions required , it has broad representation from across the division and a range of board collegues. This group monitors the delivery of the actions in the action plan, agreeing necessary changes and adaptations. It reports to the MHLD divisional Senior Leadership Team weekly in the form of a report. The group is itself dynamic, and for example, has established an estates group component to succesfully deal with the significant estate issues through Q3 2022. The Divisions estate condition and adaptability to modern clinical practice is one of the benefits in the Ablett reprovision capital project currently in process and the planning for the Hergest units potential improvements.

Evidence is collected at the time of the completion of actions. Administrative support has now also been secured to increase the robustness of the evidence bank of the NOC group.

Threats to NOC delivery/performance

There are a number of challenges to the continued delivery of the NOC group actions:-

1. The resource available
2. The operating context of the group
3. Rapidly changing field

Further detail on each is provided below.

1. Resources available.

Up until December 2022, there has been a very limited resource of people in the division to lead and deliver on the actions of the Notice of Contravention group. The Health Board also has a finite supply of health and safety specialist staff . This is an important point because the emerging approach in the UKis towardsan environmental risk assessment described as a "triumvirate" approach i.e. with support to ward/environment managers from health and safety and estate specialist specific staff to complete and update robust environmental assessments.

From a mitigation persepctive, this has been significantly addressed with investment in temporary staff members. Three part time staff (including administrative support to the group) commenced in November and December 2022. The Health and Safety and Estates teams within the Health Board are providing regular support to the NOC actions, although their capacity to support a triumvirate approach to environemtnal risk is significant. The division piloted and launched environmental risk assessment training for its staff which has been well attended and there has been positive feedback from staff attending. This positive step was reported to the Mental Health Summmit in December 2022.

2. The operating context

The operating contect of the Notice of contravention Group is also adverse. Significant waves of Covid and flu have emerged through Autumn 2022, with wider winter demand and system pressures. This is seen in the performance data through 2022 (for parts 1a and 1b of the measure). The division continues to attend to and mitigate appropriately. In addition a number of planned indutrial actions through December 2022 and January 2023 have and are impacting. This impacts again on the ability of services to release staff from front line work for training. A particular theme in the 18 outstanding NOC actions are around the resource for staff training, learning, peer audits and the monitoring of adherence to policy.

Nursing staffing vacancies have been and are a significant operating pressure. Of the 30-11-22 the division had :-

- 93.94 WTE Band 6 Nursing vacancies
- 81.52 WTE Band 5 Nursing vacancies

The vacancy situation has significantly worsened through 2022, especially for Band 6 nurses with the vacancy rates more than doubling at this level since April 2022, Band 6 nurses are the very experienced nurses who are needed to construct the risk formulation and the risk mitigation/safety plan in WARRN.

Vacancy rates in the division are deteriorating overall with 414 WTE vacancies as of December 2022 out of 2206 WTE roles at all grades. This amounts to 18.75% of all roles in MHLD.

In terms of mitigation, the division is developing flexible approaches towards and tiered levels of training where it can e.g. in clinical risk formulations and suicide awareness. The division is further developing proposals to plan for, and secure, bank and other cover to release staff for mandatory training ie WARRN. The division is also developing different ways of delivering training (for instance on a whole team basis, although this is particularly challenging for inpatient services) or using on-line methods. Releasing staff is a pressure on operational delivery in the operating environment the team are currently working within.

Improving recruitment is a key action in the divisional improvement plan and a key focus of the divisional Senior Leadership team.

3. Rapid change

Ligature reduction is a rapidly chaging field i.e. we may change one element on ligatures, based on emergin evdicen, and newer action semerge. For instance profiling beds have been replaced with lower ligature alternatives, however in practice, it has been found during manager walkabouts that lower ligature beds can be upended or have other hazards e.g. enclosed or partially enclosed castors. National updates and warnings on ligatures are regularly received and acted upon.

From a mitigation persepctive, the division launched its divisional ligature risk reduction group in December 2022 to embed (robustly) over time, the ligature reduction approaches, learning from incidents and sharing good practice. (One example of current activityis establishing standards for equipment and furniture within in-patient wards such as “fixed box type lower ligature beds and other furniture” which aims to anticipate unintended consequences). The division attends the all wales Serious Incident (SI) group which , as a group informs and shares responses and best practice nationally .

Conclusion

The above context and challenges mean that the divisional NOC group believe only a partial /incomplete assurance of the delivery of the NOC actions, can at this time be concluded, and the authors of this report therefore request to bring a further update to the QSE Committee on the continued progress of the outstanding NOC actions.

The ligature reduction focus is the prioritised improvement focus in the MHLD division. All incidents are Datix’d, and there is regular and appropriate review of all issues and learning in the Divisional Putting Things Right (PTR) meetings.

The division is actively involved in best practice forums, and is in discussion with other Health Boards and NHS Trusts. The team are sharing learning and acting on good practice early warnings, as well as alerts and good practice

The division has had significant capacity and resource challenges within the team through December and January 2022-23 as it continues with Phase 1 of the improvement plan. Meetings have been held with wider Health Board improvement approaches at Ysbyty Glan Clywyd to ensure alignment of approach and to learn from and support each others experiences . The division is progressing with the plans for wider staff engagement and contribution to the improvment journey to “make it real” for our staff and is now developing the “safer spaces”, for communication and engagement across the whole of the MHLD division and with partners of the “cogs and wheels approach” with visual display of the KPIs and phasing of the improvement and transformation plan.

MENTAL HEALTH AND LEARNING DISABILITIES

HSE NOTICE OF CONTRAVENTION OUTSTANDING ACTIONS UPDATE

Action No	Action	Target Date	Narrative update
TRAINING			
1	Undertake a Training Needs Analysis for all non-mandatory training requirements	31.10.2022	MHLD is in dialogue with the Head of Organisational Development reviewing templates of previous TNA's. OD will then support to tailor TNA to specific needs. Alternative options to procure this as a one off piece of work, if the capacity is not available within BCUHB are being explored.
2	Ensure Registered clinical staff are trained in WARRN to 86%	31.03.2023	This action is considered the most **patient safety critical** of all those outstanding. Hergest has been prioritised and will achieve 100% or thereabouts (one staff member on long term sick leave and will be prioritised on return) by the end of February 2023 following the plan that is in place. Divisionally, approximately 600 of 917 roles have received the training (63.5%). MHLD have increased the number of WARRN trainers (evaluation complete end January 2023) and the trajectory plan is being revised in order to achieve 86% compliance.
3	Ensure staff are training in the MHLD AC002 – Therapeutic Engagement and Observation Policy	31.10.2022	The newly appointed Practice Development Nurse has developed a training plan throughout 2023, where key policies and procedures are delivered to

			staff through tool box talks on site. This is part of the range of training options the division are using to deliver these training requirements.
10	Ensure nursing staff attend BCUHB Health and Safety Training Level 1 at 96% KPI	30.09.2022	Dates for Health and Safety Training are available on ESR and have been shared by the Head of Health and Safety to operational leads. Latest compliance data has been requested from ESR.
12	Once trial training has been completed, evaluate to ensure staff are confident and competent to undertake this work	30.11.2022	The HSE NOC group will provide a report, giving details of staff feedback and recommendations for taking this training forward. Consideration will be given to who will provide the training to the wider division, the frequency of refresher training and timescale for new starters to complete the training going forward. If any modifications to the session are required, these will be completed prior to planning further sessions and this will be based on the outcome of the pilot. <u>How outcomes are measured:</u> Staff evaluation feedback forms will be requested from all session attendees. The ward accreditation prompt sheets for mental health wards will be updated, to include asking staff about the implementation of the policy during the unannounced accreditation visits. This will provide ongoing assurance that staff within the inpatient wards are up

			to date with the current policy and know how to implement this within it the ward environment. <u>Expectations from Staff:</u> Staff will be expected to complete a feedback forms at the end of the session, to allow for any modifications to be implemented quickly. Staff will be expected to contribute to the discussions within the session & ask any questions that will aid their understanding of the policy. Ward managers can support and check understanding after the sessions through supervision and team meetings. <u>Possible constraints of pilot:</u> Releasing staff to undertake the training or staff not attending due to personal circumstances reducing the feedback, which is essential for this pilot. <u>Assumptions from pilot:</u> The assumption is that all staff who attend this training will gain confidence in their ability to identify to implement the policy and will understand their responsibilities within them.
13	Ensure general health and safety risk assessment training is attended – develop a programme to achieve this	31.12.2022	Dates for the general Health and Safety Risk Assessment Training are available on ESR and have been shared by the Head of Health and Safety to operational leads. Latest compliance data has been requested and from that data a performance trajectory will be developed to improve performance from the benchmark.

14	MHLD staff 8d and above attend IOSH – Leading Safely Course – develop a programme to achieve this	31.12.2022	Divisional Senior Leadership Team have circulated the dates to senior staff and reiterated the requirement to attend this training. Compliance data has been requested. Five dates through to January 2023 were circulated. More dates awaited as or if required.
AUDIT			
4	Audit all MHLD inpatient units using agreed audit tool to include MHM and Risk assessment	31.12.2022	Staffing resource has now been identified to undertake this significant piece of work which is now progressing with an anticipated target date of mid-February.
5	Develop an audit protocol that clearly sets out all audit activity and reporting. This should include KPIs	30.10.2022	This work was completed in December 2022 and approved as completed by the NoC on 09.01.2023.
7	Audit compliance with nursing supervision against MHLD CPG0022	30.10.2022	The MHLD Supervision procedure has been approved. Managers are asked to input all supervisions to ESR as 'external learning' with a report every quarter the Wellness, Work & Us team. Managers are currently in transition from recording on local records (which has been the practice in some areas) to recording on ESR to ensure that all Supervision is accurately recorded reportable, with compliance being monitored.
11	Audit compliance with the Restricted items procedure and implement an improvement plan if required	30.06.2023	The Procedure review, consultation and approval has been progressed through the Health Board process. Training is being delivered as per Action 3 and 12 above. Following completion of the pilot an audit programme will commence.

			Target date for completion of this action has been extended to accommodate the longitudinal nature of this work.
15	Audit the application of MHLD search procedure	30.06.2023	The Procedure review, consultation and approval has been progressed through the Health Board process. Training is being delivered as per Action 3 and 12 above. Following completion of the pilot an audit programme will commence. Target date for completion of this action has been extended to accommodate the longitudinal nature of this work.
16	Audit the application of the BCUHB Patient Property procedure and implement an improvement plan	30.06.2023	The Procedure review, consultation and approval has been progressed through the Health Board process. Training is being delivered as per Action 3 and 12 above. Following completion of the pilot an audit programme will commence. Target date for completion of this action has been extended to accommodate the longitudinal nature of this work.
QUALITY IMPROVEMENT AND LESSONS LEARNT			
9	Implement robust Health and Safety system based on HSG65	31.08.2022	H&S reviews completed for Aneurin, Cynan & Taliesin were undertaken in August 2022 with ongoing self-assessments being undertaken locally in accordance with H&S system.

6	Use baseline data to triangulate themes and trends using agreed KPIs in order to identify good practice and practice that requires improvement and development	31.10.2023	Much of the data required for triangulation is being collected as part of ongoing training and audit actions. The NoC will consider whether the target date for completion of this action should be extended to accommodate the longitudinal nature of this work.
17	Consider holding a Learning Event to share practice across MHLD and BCUHB	31.12.2022	Once the triangulation of data exercise has been completed, a Learning Event will be organised. The NoC will consider whether the target date for completion of this action should be extended to accommodate the longitudinal nature of this work.
18	Consider different communication methods of disseminating lessons learned eg 7 minute briefings, recordings, team meetings – discuss with improvement team methodologies to support	31.12.2022	A compendium of 7 minute briefings has been established. It has been agreed by learning from other organisations that a 'red alert' system will be embedded to replace or supplement the control memos.
19	Develop a lessons learned programme for all incidents and near misses to ensure lessons are implemented and tested	31.12.2022	The previous thematic analysis is to be revisited once the training, audit and triangulation has been completed to inform the lessons learned programme. The NoC will consider whether the target date for completion of this action should be extended to accommodate the longitudinal nature of this work.
DATA SYSTEMS			
8	Implement a digital patient record system	31.06.2023	The Head of Informatics, Programmes, Assurance and Improvement has advised that the Welsh

			Community Care Information System (WCCIS) is the Electronic Patient Records for inpatient mental health, a non-mental health pilot has commenced on Ynys Mon and the full roll out dates are to be agreed in Q1 2023/24 subject to an evaluation. Anticipated completion date 31.03.2024

Teitl adroddiad: ***Report title:***	YGC Improvement Plan (Central IHC Journey to Excellence)
Adrodd i: ***Report to:***	Quality, Safety & Experience
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023
Crynodeb Gweithredol: ***Executive Summary:***	This paper provides a standing update on the progress being made with regards to Targeted Intervention at Ysbyty Glan Clwyd, including the evolution of the plan into a wider Central Integrated Health Community approach which is now being referred to as the Journey to excellence, reflecting the ambition of longer term transformational goals. The report highlights progress over the last two months and areas where improvements are beginning to take effect, whilst also identifying the scale of challenges remaining. The report includes the period relating to industrial action, both within the nursing workforce and our partners in the ambulance service. In addition to the operational challenges posed during these days, the planning for these events has limited the ability of colleagues to commit the same level of time to the transformation programme during the latter part of this period. Improvement activities have nevertheless continued to progress and preparations are now complete for the Acute Assessment workshop on the 17th January, a clinical event that is a critical juncture in our journey as we design our assessment model for the future, which will form a large part of our plan over the next 12 months. HIW related actions and Vascular are covered via separate papers.
Argymhellion: ***Recommendations:***	The committee is asked to note the update on progress to date and the challenges that remain.
Arweinydd Gweithredol: ***Executive Lead:***	Dr Chris Stockport, Executive Director Transformation, Strategic Planning, and Commissioning; Gill Harris, Interim Chief Executive

Awdur yr Adroddiad: ***Report Author:***	Gaynor Thomason, Programme Director Clinical Safety Improvement Geraint Parry, Quality Improvement Fellow, YGC			
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):***	6 goals for Urgent and Emergency Care			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	This plan addresses the improvements identified as being required by HIW.			
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 – standing update paper			
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 – standing update paper			
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)***	CRR Ref 3873 – Inability to deliver safe, timely and effective care CRR 20.06 – Record keeping			
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A			
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith	N/A			

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***	N/A
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	CRR Ref 3873 – Inability to deliver safe, timely and effective care CRR 20.06 – Record keeping
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:*** Continuation of the Transformation Programme	
Rhestr o Atodiadau: Appendix 1 – YGC Improvement Plan ***List of Appendices:*** Appendix 1 – YGC Improvement Plan	

Quality, Safety and Experience Meeting
20th January 2023
YGC Improvement Plan (Central IHC Journey to Excellence)

1. Introduction / Background

This report is part of a regular update relating to the YGC site which is currently subject to Welsh Government Targeted Intervention arrangements. It sets out progress since the last update and how plans are maturing into a wider Integrated Health Community (IHC) plan, referred to as the Journey to Excellence.

2. Body of report

What has changed / what have we developed since the last update?

The weekly meetings for each of the individual work streams have gathered pace with strong clinical engagement evident. Individual project teams have been scoping the challenges in each area and developing project plans to address issues and identify opportunities for change. All of this work is underpinned by the Betsi Way, ensuring a systematic approach to problem identification, recognising this process as a key foundation for embedding success further down the line.

As individual projects have met, an early piece of learning has been the interdependencies between key streams of work, and a number of these have now been integrated into clusters as depicted in the following table

Project/Cluster	Components
Acute Assessment Area	Frailty, Acute Assessment Unit, SDEC
Clinically safe alternatives to admission to hospital	Front Door Clinical Streaming, UPCC, Emergency Admission Risk Stratification, Paramedic/Community Intervention Teams, Alternative Pathways to ED
Right Patient, Right Place Phase 1	Real Time Demand and Capacity, Long Length of Stay, Board Rounds, Discharge Unit
Right Patient, Right Place Phase 2	Criteria to Reside and Criteria Led Discharge, Integrated Discharge Liaison Team
START	Stand-alone project
Children and Young People in ED	Stand-alone project

As clinical groups have met and identified problem areas, spin-off pieces of work have been commissioned by the Director of Operations to delve further into the issues and report back to the main group. An example of this is a strand of work being led by the Transformation team, labelled as ‘Frailty – missed opportunities’. Intelligence from data analysis has identifed that some patients are staying in the unit for too long, contrary to the agreed model, which is inhibiting other potentially suitable patients from being placed into the Frailty Unit. Good progress has been made in identifying the exact point in the process where opportunities are being missed, and the work is now moving to design phase as more simplified assessment processes are agreed. This work all feeds into the wider acute assessment model which is key to future success.

Following significant preparation work over the past few months the newly refreshed Discharge Unit was formally launched on the 8th November with a strengthened staffing model including pharmacy support which will enable a step change in the service model. The unit will take a more central role in the functioning of the site on a daily basis, placing a greater emphasis on pull from the wards and driving earlier movement during the day.

Following concerns highlighted around the consistent implementation of safety huddles, a review is underway with regards to course correction utilising a recognised improvement approach. A candid assessment has been undertaken by the clinical team, acknowledging the areas where engagement has been seen to wane and working through both the practical and cultural issues that impact upon this. Despite feedback that a number of other ED's do not undertake huddles in this manner, it is evident that the team remain committed to the concept of undertaking these regular safety check-ins, and have made proposals to strengthen the process. A member of the EQ management team has also committed to taking forward this improvement as part of the IHI leading for improvement programme, demonstrating an important link between our existing areas of challenge, and the opportunities we are providing staff to upskill themselves and learn new ways of tackling old problems. Importantly this has led to a wider engagement piece of work with the whole team to understand the wide range of views on what does work currently, and the reasons for challenges remaining.

A review of the first phase of the START project which was implemented in May has taken place, recognising the current improvements delivered and where the challenges remain. Money is available from Welsh Government to undertake improvements to waiting rooms across Wales and the team are accessing this fund to ensure that the estate can best support the patient flows through the department and support the collegiate working between nursing and medical staff.

Building upon the increasingly firm foundations of the Medical Integrated Board, a range of topics have been debated over recent weeks with clinically led peer challenge on how to deliver continuous improvements. A much improved collaboration with the HMT is evident and one recent test of change is testament to this. Whilst in-reach across the majority of specialties had previously been improved upon, Cardiology remained an outstanding area and following detailed discussion on the multi-factorial reasons for this, including capacity constraints, agreement was reached for the Consultant of the week to work with the Director of Operations around testing new ways of working, and this will continue to be tested and evaluated. A review of data around medical clerking delays overnight also saw agreement to implement an earlier start time to a shift to provide overlap and ensure delays didn't impact on Consultant processes in the morning. This change was volunteered from within the team and reflective of the good clinical relations being built.

December also saw the launch of the Leading for Improvement programme, led by the Institute for healthcare improvement, and the feedback from the first session was very positive with strong enthusiasm apparent and a further signal that staff are welcoming the engaging approach being promoted and them being supported to own and solve their own problems, with appropriate external support, as opposed to previous efforts where staff have felt "done to".

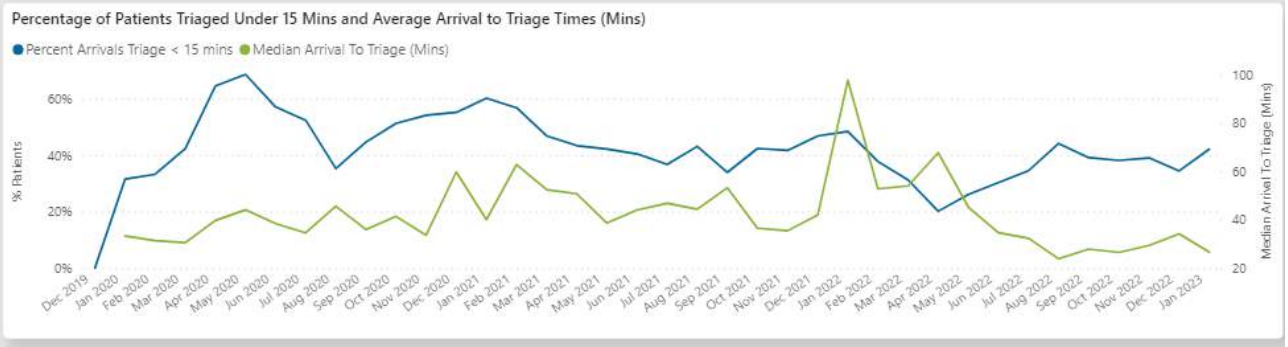
Engagement has also taken place with the clinical leads within the Surgical Directorate to outline the structure of journey to excellence and what is required within the planned care environment. Building on the inception of the Medical Integrated Board which has been a key driver for clinical engagement with physicians, there is now agreement to set up a similar Surgical Integrated Board, and the ultimate outcome will be a planned care improvement plan, which this Clinical Board would help to drive forward.

What Improvements has this led to?

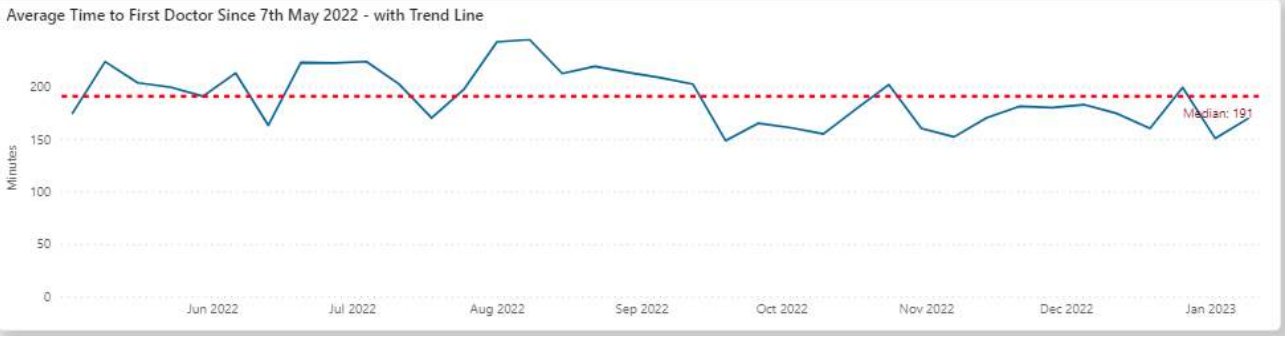
The focused work at the front door is continuing to deliver improvements to patient care and resulting in reduced risk for patients. This work has delivered reduced waits for both triage and for initial assessment by a doctor, although as alluded to a review of START will lead to further redesign work to deliver the wider pathway benefits to negate patients needing to return to the waiting room.

As previously reported to cabinet, improvement science techniques are being utilised to monitor and evaluate impact, and importantly these improvements are beginning to embed and sustain. It has been recognised from the beginning that improvement does not always occur in a linear fashion, and whilst winter pressures coupled with industrial action poses significant challenges, it is pleasing to note that improvements are holding up despite that increased pressure.

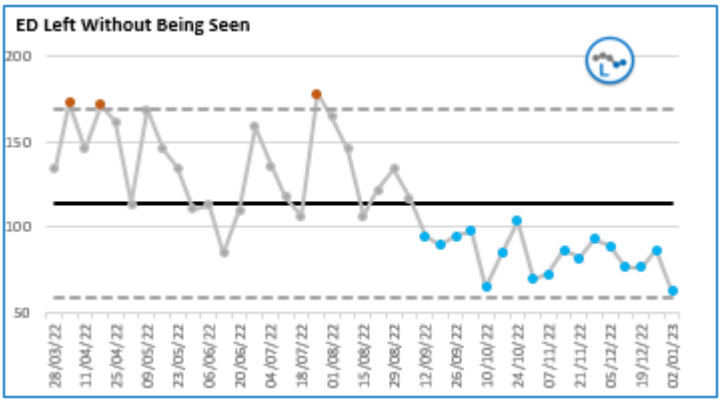
The following chart for triage times demonstrates significant reduction in the median time (green line) and increased percentages seen within 15 minutes (blue line). As alluded to, the Christmas and new year period is always a challenge for the acute sector but new processes are standing up to these pressures and improvements being maintained.



This improvement is mirrored in the times to a see a doctor, and whilst the Christmas and new year week was the most challenged, this remained within the new range.

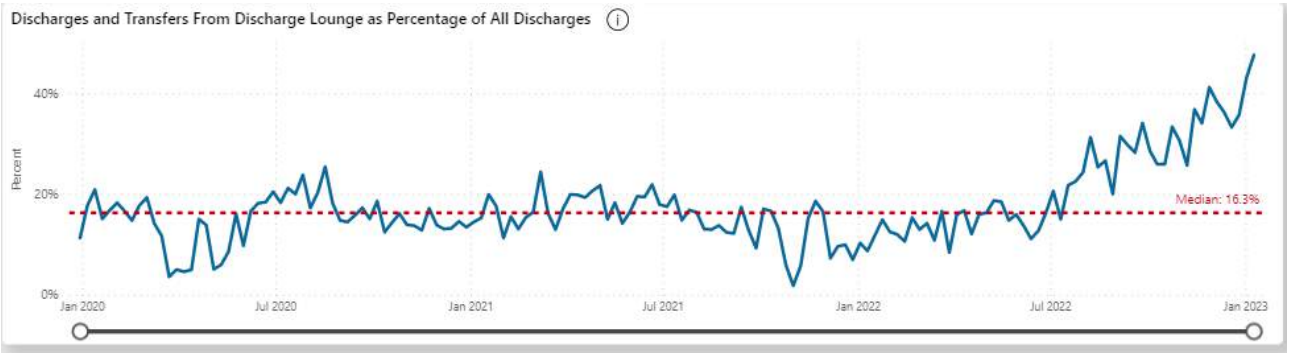


These improvements are also beginning to have a direct impact on the numbers of patients leaving ED without being seen, an important safety and patient experience metric. This has reduced from a high of 14.3% in April to a current rate of 7% which again has been maintained through the seasonal pressures into new year and providing assurance that new processes are able to function under increased pressure. Further work still remains to bring below the 5% standard.

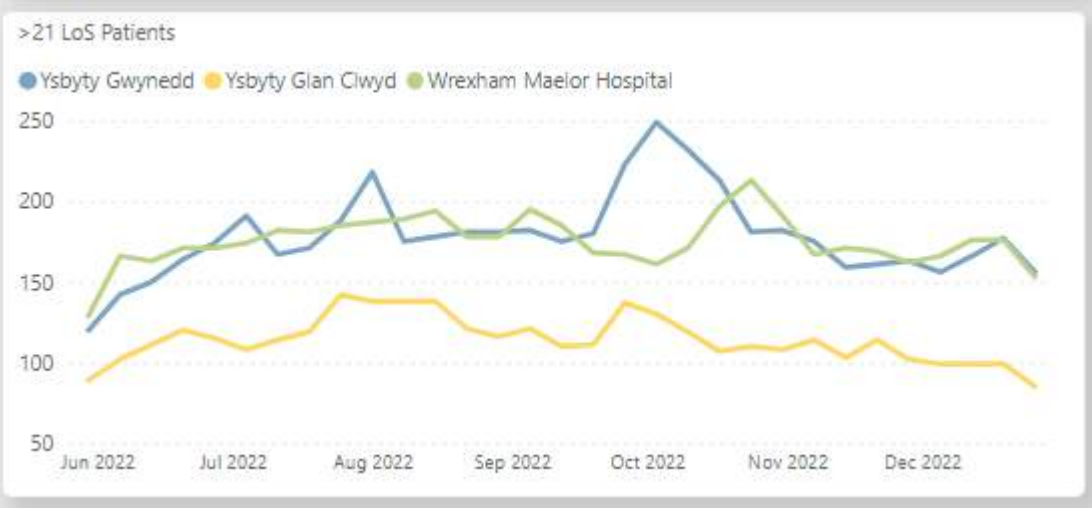


The breadth of work to launch the new discharge unit has also begun to deliver early benefits, with a greater proportion of the site's discharges happening via the unit. Embedding this into the daily rhythm of the site will be a key transformational change in terms of flow through the hospital with further improvements expected. These are the foundational steps in terms of working with wards to think of this discharge pathway by default, and working as part of the Right Patient Right Place cluster, this will begin to dovetail with the work around Real Time Demand and Capacity and lead to discharges occuring earlier on in the day. Early informal feedback is positive with our colleagues in the non emergency transport service describing a noticable difference in functioning, and more formal evaluation will take place at an appropriate juncture.

The following chart is again demonstrating a recognised shift which is directly linked to the changes that have been implemented, and improvements have continued during recent weeks and providing a critical support to the site in helping to recover more quickly from pressure periods.



Within the Right Patient, Right place cluster of work, there is continued focus on long length of stay patients with improvements again noted. The following chart highlights the reductions occurring in YGC (yellow line) and the overall favourable position for YGC when set in a BCU context.



What are our concerns?

Whilst a series of improvements are beginning to be noted across the board, this is yet to translate into larger scale improvements across the system and challenges persist in relation to patient flow and crowding. A significant contributory factor is the scale of patients across both the acute and community hospital settings who are medically fit for discharge but unable to move onto a place more suitable for their current need. The unavailability of packages of care is proving to be a barrier that is placing constraints on the hospital setting and is diluting the impact of other improvements which staff have strived hard to deliver. This is costly to the health economy, both in financial terms and in the delays and potential harm for patients trying to access the system. There is a further concern that this contributes to, which is the morale of staff who have remained positive and engaged with our change activities despite the strain they are under and this could impact on the sustainability of their change efforts.

These challenges, common to all hospitals across the UK, have persisted through the Christmas period, and coupled with the impact of a series of a strike days, place significant strain on our system. Furthermore, the levels of crowding that ensue not only provide operational challenges but does not provide an environment most conducive to enacting change.

There are a number of concerns within the planned care element of the journey to excellence. Whilst the initial priorities have been around the unscheduled care challenges, work had been progressing in the background in relation to elective work. A review has now taken place and a decision to pause this phase of work in the context of journey to excellence, and the interim project management support released. It was evident that many of the activities that were being focused upon were more akin to business as usual and not akin to transformation. These foundation activities will continue via operational teams in preparation for later transformation work, and simultaneously a scoping exercise will take place to work through the breadth of work underway in this area and design a more appropriate transformation programme. More specifically a number of these concens relate to theatre utilisation.

There is some concern in relation to leadership and culture in Urology, which initially came to the fore during a royal college of surgeons review and this has been compounded by findings around in-reach and responsiveness during the HIW visit. Furthermore as we continue the transition from HMT to the new IHC further work is required around nursing leadership and visibility on site as roles and responsibilities have changed and ensuring expectations are clear.

Further concerns include the following:

- The BCU financial position and its potential impact on the Journey to Excellence
- The lack of maturity in terms of triangulation and the requirement to develop the scope of work in this area
- Issues around documentation and how to progress challenges that are broader than individual service level and are BCU wide in nature
- The project resource and the scale of challenge that remains ahead of us versus the resource available to drive forward

What is the focus for the next period?

The significant focus for the next period is the Acute Assessment Area workshop which is being held on the 17th January. This event will bring together a range of key stakeholders across the multi-disciplinary team to design the future model of care. This is a critical step in working through the interdependencies and overlaps and ensuring clinical debate around the development of new models of care.

A particular area of focus will be the development of the medical model to support emergency care, incorporating the post take ward round, the most appropriate configuration of the assessment units and the resultant flow of patients to specialty wards to ensure patients are looked after by the most appropriate specialty. Preparatory work has taken place, supported by Dr Ruth Alcolado, and the workshop is likely to be the start of significant work over the coming months to develop pathways that are fit for purpose and future proofed.

The task and finish review of Real Time Demand and Capacity, supported by Improvement Cymru, which was deferred due to industrial action, will re-commence on the 6th February and will run throughout this period with wards reviewing and refining the way in which they plan for discharges the following day. This work will integrate closely with existing daily processes on site, such as the 1pm Check and Challenge meeting, building upon existing foundations and ensuring a continual evolution of our approach to more proactive planning at all levels of the system.

On the planned care side a scoping exercise is underway, bringing together all the existing information, actions and plans into one overarching plan. This work will delineate between work that is essentially business as usual and in need of a continuous improvement approach and the longer term transformational requirements. More specifically an urgent piece of work is already underway and will continue around Pre Operative Assessment Clinic (POAC) and addressing some of the significant challenges in this area which is also a key interdependency for optimising theatre utilisation.

More broadly, the governance arrangements within the IHC are progressing. The new Transformation Group is due to meet for the first time on the 23rd January and will set out the IHC's transformation and planning agenda for the year ahead. Additionally, the bespoke 'Leading for Improvement' programme continues with the scond session on the 24th January where colleagues will be taking forward various small scale initiatives as part of their training, in what is a fantastic opportunity to upskill our workforce in order to support sustainable change for the long term.

3. *Budgetary / Financial Implications*

There are no specific budgetary implications associated with this paper.

4. Risk Management

The following risks are established corporate risks.

CRR Ref 3873 – Inability to deliver safe, timely and effective care
CRR 20.06 – Record keeping

5. Goblygiadau Cydraddoldeb ac Amrywiaeth / *Equality and Diversity Implications*

Not applicable

Teitl adroddiad: **Report Title:**	Vascular Services Update		
Adrodd i: **Report to:**	Quality Safety and Experience (QSE) Committee		
Dyddiad y Cyfarfod: **Date of Meeting:**	20 January 2023		
Crynodeb Gweithredol: **Executive Summary:**	The purpose of this paper is to 1. update the QSE on the progress of the Vascular Network against the Vascular Targeted Intervention Programme 2. update the QSE on recent clinical governance activity The network has made progress since the previous QSE committee, notably with pathway development and completion of actions arising from various reports and inspections. The recent visit from Health Inspectorate Wales (HIW) did not generate any new concerns. The National Vascular Registry report highlighted significant improvements as well as areas for further development. The risk in the service has reduced. Recent local audits into consent processes and amputation rates and outcomes have provided assurance of progress.		
Argymhellion: **Recommendations:**	The committee to note the summary of actions taken since the last update.		
Arweinydd Gweithredol: **Executive Lead:**	Dr Nick Lyons – Executive Medical Director		
Awdur yr Adroddiad: **Report Author:**	Jenny Farley – Vascular Network Director		
Pwrpas yr adroddiad: **Purpose of Report:**	I'w Nodi For Noting ☐	I Benderfynu arno For Decision ☐	Am sicrwydd For Assurance ☒

	Arwyddocaol Significant	Derbyniol Acceptable	Rhannol Partial	Dim Sicrwydd No Assurance
Lefel sicrwydd: **Assurance Level:**	☐ Lefel uchel o hyder/tystiolaeth or 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 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):**	Delivery of the recommendations set out by the Royal College of Surgeons review of Vascular Patient Medical Records
Goblygiadau rheoleiddio a lleol: **Regulatory and legal implications:**	None
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?**	Not applicable – This paper does not reflect a change in service
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?**	Not applicable – This paper does not reflect a change in service
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)**	CRR22-25: risk of failure to provide full vascular service due to lack of available consultant workforce CRR22-26: Risk of significant patient harm as a consequence of sustainability of the acute vascular service CRR 22-27 Risk of potential non-compliance with regulatory standards for documentation due to poor record keeping - Vascular services
Goblygiadau ariannol o ganlyniad i roi'r argymhellion ar waith **Financial implications as a result of implementing the recommendations**	None
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith **Workforce implications as a result of implementing the recommendations**	Not applicable
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori **Feedback, response, and follow-up summary following consultation**	Not applicable

Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) **Links to BAF risks:** (or links to the Corporate Risk Register)	CRR22-25 CRR22-26 CRR22-27
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:**	Continuation of the transformation programme
Rhestr o Atodiadau: **List of Appendices:**	

QUALITY, SAFETY AND EXPERIENCE

20 JANUARY 2023

VASCULAR NETWORK TEAM TARGETED INTERVENTION PROGRESS

1. **Introduction / Background.** The Vascular Network Team has continued to transition to the Targeted Intervention approach to Vascular Services and the updates below set out the progress to date.

2. **Pathways Update.**

(a) **Emergency ischaemic limb**

(1) The BCUHB Vascular Network, WAST and the three Emergency Departments have developed pathways for patients who suffer an acute ischaemic limb to be conveyed directly to the major arterial centre at Glan Clwyd Hospital, from all geographical areas of North Wales. The pathways are being tested and will be ratified at the multi-disciplinary vascular clinical governance meeting on 17 January 2023 before they are uploaded to the SharePoint site.

(2) The pathways cover the various ways in which patients present and how they then get safely managed by the right team in the right place.

(3) This is an important programme of transformation which has already significantly reduced the delays. An assessment space has now been established within Ward 3 so that patients with confirmed ischaemic limbs may be taken directly there upon arrival at the hub for full in-person clinical assessment by the vascular team.

(4) Plan, Do, Check, Act (PDCA) bi-weekly meetings have been established to monitor trends, capture incidents and if necessary, modify the pathway to meet unforeseen issues. These meetings will be chaired by a member of the Vascular Network Team and run for six months in the first instance.

a. **Renal Pathways.**

(1) There have been two Renal mapping exercises held since the last Vascular Steering Group (VSG).
(2) The first focused on mapping the current and future pathways for fistula creation. The second (held on the 15 December 2023) focused on issues, risks and actions arising from the implementation of the future fistula pathway.
(3) These have been fed into the Renal Peer Review action plan with following sessions identified to assign owners and timings.
(4) Further away days/meetings for Renal are to cover:

(a) Peritoneal Dialysis (PD) Pathway.

(b) Identify the Multi-Disciplinary Team (MDT) job planning requirements which will need to be addressed by the surgical and diagnostic management teams.

b. **Diabetic Foot.**

(1) The second Diabetic Foot summit that was planned for November 2022 had to be moved due to conflicting agendas and is now planned for the 13 January 2023.
(2) It will focus on the following topics:
(a) What our data is telling us.
(b) Process mapping the Emergency Diabetic Foot Service and identify the difference in services on each site.
(c) Compare the process map against NICE guidance principles.

(d) Design future service states in line with NICE guidance.

(e) Prioritisation of improvements/actions.

(f) Next steps.

(3) The next summit/workshop will be planned for six weeks' time approximately the end of March 2023.

c. **Long term transformations.** Several long-term transformations are the responsibility of the Vascular Network Team and include:
(1) Suite of investigations for every patient with an abdominal aortic aneurysm (AAA).

(2) Discharge planning to include all MDT members and starting from admission.
(3) Rehabilitation.

(4) Patient Length of Stay.

(5) Hot clinics and virtual ward.

3. **Targeted Intervention (TI) Plan.**

a. The following are completion percentages with respect to the actions arising from the various reviews and inspections:

(1) Royal College of Surgeons – 67%.
(2) Vascular Quality Panel – 76%.
(3) All other – 70%.

4. **Health Inspectorate Wales (HIW) visit.**

a. HIW visited BCUHB and met with the vascular network team and various clinical staff on 13-15 December 2022.

b. Verbal feedback from the Senior Healthcare Inspector (a consultant vascular surgeon) during the meeting was positive with no red flags raised. She intimated that there would be no formal report from the visit unless they found anything significant. A request was made to HIW for an email/letter to be written on completion of the review to feedback to all concerned in the department, to which they agreed.

c. In their verbal feedback HIW:

(1) Acknowledged the amount of progress made.

(2) Approved the action plan format and were appreciative of the dashboard providing basic statistics.

(3) Commended the pathways for Emergency Ischaemic Limb and the process that has been put in place to monitor delivery.

(4) Acknowledged the progress on Renal pathways and action plan.

d. All evidence was sent to the Senior Healthcare Inspector including the Vascular Network Team Plan on a Page.

5. **Vascular Network Plan.**

a. The Vascular Network have produced a Plan on a Page to outline our:

(1) **Mission: T**o be a Network that inspires our workforce and fulfils our patients' expectations.

(2) **Vision:** We strive to deliver clinically outstanding vascular care with kindness, compassion and humanity to our patients, their family, carers and workforce teams.

(3) **Priorities:** How we intend to deliver them, what targets we have set and what success looks like**.**

6. **Plan, Do, Check, Act (PDCA) Cycle.**

a. Every transformation within the remit of the Vascular Network will also incorporate a six month, bi-weekly set of meetings, post transformation utilising the PDCA Cycle.

b. These meetings will have Terms of References (ToR) and meeting agendas formulated and distributed. Each ToR will incorporate an explanation of the PDCA cycle to assist Stakeholders with the methodology.

7. VASCULAR NETWORK CLINICAL GOVERNANCE UPDATE

a. Data from the 2022 National Vascular Registry (NVR) report confirmed activity and outcomes are broadly in line with the national average. A summary of the findings is in **Appendix 1** and the themes will be taken forward by the vascular steering group, the vascular network and the operational teams. Data entry was not complete for all fields.

b. Tier three audits have taken place into vascular access, timing of revascularisation, amputation rates and outcomes and consent processes. These are discussed at the vascular clinical governance sessions and the vascular steering group.

c. Since the last QSE two risks have been closed on the risk register. Ten have had their ratings reduced and 11 had their ratings unchanged. There were no deteriorations in the ratings.

d. A planned Quality Assurance visit by the Welsh AAA Screening programme is due to take place in early 2023 (the date has been agreed yet).

8. **Budgetary / Financial Implications.** There are no budgetary implications associated with this paper.

9. **Risk Management.** As set out on the cover sheets.

10. **Equality and Diversity Implications.** Not applicable.

Appendix 1: Summary of NVR report

<u>Areas of good performance</u>

Clinical

Within national expectations

- Mortality and case load for lower limb revascularisation
- Diabetic foot MDT clinic
- Post-operative death / stroke after carotid endarterectomy
- Delays to surgery for carotid endarterectomy
- Length of stay for abdominal aortic aneurysm (AAA) repair
- Mortality and case load for major amputation
- Above knee amputation (AKA):below knee amputation (BKA) ratio
- High proportion of patients with AAA having MDT discussion, pre-operative CT and formal anaesthetic assessment

High levels of

- Consultant presence for amputation
- Antibiotic prophylaxis given for amputation

Good organisational performance in terms of

- Consultant review within 48 hours for all admissions
- Clinic spaces for urgent assessment of critical limb ischaemia (CLI)
- Staffing numbers: Consultant surgeons; Specialist nurses; access to Healthcare of the Elderly consultants; Vascular scientists
- Number of elective operating sessions
- Dedicated endovascular lists in the Interventional Radiology suite
- Access to hybrid theatre
- Same day imaging
- Ring fenced urgent angioplasty slots
- Specialised amputee rehabilitation centre (Artificial Limb and Appliance Centre in Wrexham)

Areas for improvement

Clinical

- Increase proportion of patients undergoing revascularisation within 5 days of admission for CLI
- Further explore the mortality rate for lower limb revascularisation.
- Examine reasons for AAA mortality rate (4.4%) after elective AAA repair in context of this being within the 95% control limit but higher than national mean (1.4%)
- Consider the high proportion of Endovascular Aneurysm Repair (EVAR) to open repair for elective AAA
- Examine processes that would reduce delay to AAA repair after referral
- Examine possibilities for provision of 24/7 emergency EVAR service to increase proportion of EVAR for ruptured AAA
- Recognise that the AKA:BKA ratio is less than 1 and audit failure to heal rates in BKA
- Need to reduce delay to amputation after vascular assessment for patients requiring this procedure

Organisational

- Need diabetic foot MDT ward round
- Need specialist amputee rehabilitation team, including psychology
- Need amputee physiotherapist in arterial centre
- Need more vascular interventional radiologists
- Need data support staff for interventional radiologists for NVR
- Need allocated operating lists for vascular emergencies
- Need supervised exercise programme

Cyfarfod a dyddiad: Meeting and date:	**Quality Safety and Experience Committee** 20 January 2023
Cyhoeddus neu Breifat: Public or Private:	Public
Teitl yr Adroddiad Report Title:	Urology Network update
Cyfarwyddwr Cyfrifol: Responsible Director:	**Nick Lyons -** Acting Deputy CEO, Executive Medical Director.
Awdur yr Adroddiad Report Authors:	**Karen Mottart** - Acting Deputy Executive Medical Director, Consultant in Anaesthesia and Intensive Care Medicine **Dino Tedaldi** – Urology Network Manager
Craffu blaenorol: Prior Scrutiny:	**Emma Hosking** Acting Deputy Executive Medical Director, Consultant in Anaesthesia
Atodiadau Appendices:	None

Argymhelliad / Recommendation:

The committee is asked to receive the update on the current position in Urology and the the progress to improve the quality and sustainabilty of the service for the population of North Wales.

Ticiwch fel bo'n briodol / Please tick as appropriate

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

Sefyllfa / Situation:

The Urology service is in the process of reconfiguring its work to deliver a network in which specialised care is offered in fewer centres and routine, high volume care is offered as close to the patients' homes as possible.

There is variation in performance between the three acute sites particularly for men with suspected and confirmed prostate cancer. Waiting times for prostate cancer treatment are too long and in some cases patients have come to harm.

Certain specialised procedures are delivered locally for some patients but some patients are travelling to England. There is currently no robot assisted surgical provision for prostate surgery in the Health

Board. Robotic-assisted prostatectomy surgery was due to start in December 2022. For patient saftey reasons this has been postponed.The network is working with the National Programme clinical lead to resolve the situation.

Outcomes in bladder cancer surgery have improved following the appointment of a specialist surgeon to Ysbyty Gwynedd.

The Urology Improvement Group, led by Dr Karen Mottart, will execute an improvement plan informed by recommendations from the Royal College of Surgeons and the Getting it Right First Time team. The Urology Improvement Group will report to the Urology Steering Group chaired by Dr Nick Lyons. The Urology Steering Group will report to the Quality Safety and Experience committee.

Cefndir / Background:

In January 2020 an internal report was published in draft form addressing the challenges of Urology service delivery in North Wales. It identified that the current Urology service struggled to meet demand, particularly for major pelvic cancers. This resulted in some patients being sent to England, in particular for prostatectomies. It also noted that recruitment and retention of consultant Urologists was a persistent challenge, resulting in each of the three departments becoming heavily reliant on locum and agency staff. There is an annual expenditure of £1 million on medical agency staff.

The review in 2020 identified four options for the service. The preferred option was to develop a fully networked multi-professional Urology service with consolidation of major pelvic cancer surgery at Ysbyty Gwynedd, and complex renal stone surgery at Ysbyty Wrexham Maelor. All three sites will continue with day-case work, with Ysbyty Glan Clwyd providing expertise in high volume day case and 23.59hrs surgery.

Royal College of Surgeons Invited Service Review

The Royal College of Surgeons (RCS) carried out an Invited Review (IR) of the BCUHB Urology service on 14-17 November 2022. The final report is due in March 2023.

The RCS review team

- Spent two days reviewing 50 randomised case notes from each acute site
- Conducted site walk rounds at Ysbyty Glan Clwyd and Ysbyty Wrexham Maelor
- Conducted 18 interviews, which were a mix of one-to-one and group interviews

A further one-day visit will take place at Ysbyty Gwynedd on **23 January 2023** in order for the IR team to review the entirety of the Urology service.
The IR team worked with the Health Board to consider the standard, safety and quality of the current service configuration and provision, and advise on ways that the Health Board could improve and sustain a resilient, high quality Urology service.

Getting it Right First Time (GIRFT)

The Welsh Government commissioned GIRFT to review Urology services within Wales. The GIRFT review at the Health Board took place on 3 November 2022 and the team issued a draft report in early December 2022.

Two issues were identified, both of which are now on the risk register as detailed below.

Risk Register ID 4657 - On call risk – YGC
Risk Register ID 4660 – Robotic surgery risk – BCU – Linked to Ysbyty Gwynedd due to robot location.

With respect to the on-call risk the network has made a recommendation which is currently being considered by the executive team.

The robotic risk will be described later in the paper.

The recommendations from the Royal College IR and the GIRFT review will feed into the Urology improvement plan which aligns to the Health Board's transformation and improvement approach, and is in line with the relevant NICE guidelines including **Prostate cancer: diagnosis and management (NG131).**

Robot Assisted Surgery

> *Commissioners of urology services should consider providing robotic surgery to treat localised prostate cancer. Commissioners should base robotic systems for the surgical treatment of localised prostate cancer in centres that are expected to perform at least 150 robot-assisted laparoscopic radical prostatectomies per year to ensure they are cost effective.*

NICE guidance 131, **2014**

Two centres in South Wales already use the da Vinci robot for radical prostatectomy surgery. At present North Wales patients primarily go to University College Hospital in London for robot-assisted prostatectomy. A small number go to Liverpool University Hospitals Foundation Trust.

In March 2022 NHS Wales awarded a multi-year contract to CMR Surgical (CMR) as part of the National Robotics Assisted Surgery Programme. CMR is a global surgical robotics business and the intention of the national programme is for the CMR system to be used for colorectal, upper gastrointestinal, gynaecology and urological specialties.

The CMR system was delivered to Ysbyty Gwynedd in March 2022 and commissioned in May 2022. The first gynaecology cases took place in September 2022. Health Board colorectal surgeons are undergoing additional training in April 2023.

Pathway Transformation

The network and the Transformation and Improvement team have prioritised the prostate cancer pathway for review and improvement.

Three Prostate Cancer Pathway redesign workshops took place in September and October 2022, supported by the transformation team. Five task and finish groups were set up to:

1. Refine referral criteria from primary to secondary care
2. Implement direct access to diagnostics from primary care without the need to see a consultant first ("straight to test")
3. Help patients make informed decisions about treatment options

4. Standardise follow up across all three sites (to include Prostate Specific Antigen [PSA] tracker)
5. Reduce the backlog of prostate biopsies and extend the roles of other members of the multi-professional team

The task and finish groups will conclude by mid-February 2023. Following this, the proposed pathway will require a two-week consultation period before the final sign off in March 2023.

Asesu a Dadansoddi / Assessment & Analysis

Goblygiadau Strategol / Strategy Implications

The Urology service remains vulnerable due to shortages of substantive consultants and is unsustainable in its current configuration. Royal College, GIRFT and internal reviews align in terms of recommendations as to how to improve.

The integrated health communities will work with the network to ensure implementation of the new pathway for prostate cancer. While robotic assisted surgery is established in North Wales the Health Board will continue to commission robotic assisted prostatetcomy from University College Hospital, London.

Goblygiadau Ariannol / Financial Implications

The financial implications will be described when the improvement plan is complete.

Dadansoddiad Risk / Risk Analysis

The main risk is the challenge of adopting new ways of working and moving from three distinct teams to one networked service which provides high quality, standardised care across North Wales.

Cyfreithiol a Chydymffurfiaeth / Legal and Compliance

Currently under consideration

Asesiad Effaith / Impact Assessment

Currently under consideration

Teitl adroddiad: ***Report title:***	Patient Safety Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023			
Crynodeb Gweithredol: ***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.			
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Dr Kath Clarke, Assistant Director of Patient Safety Sarah Musgrave, Patient Safety Lead Manager			
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:***				
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.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***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.			
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?	N/A			

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)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
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) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Patient Safety Report	

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

Patient Safety Report to the QSE Committee October-November 2022

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

Patient Safety Report
October 2022 – November 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.

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.

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

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 nationally is within seven working days.

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 October and November 2022, 25 nationally reportable incidents were reported to the Delivery Unit. There has been no change in the number of reportable incidents since the previous report for August and September 2022.

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

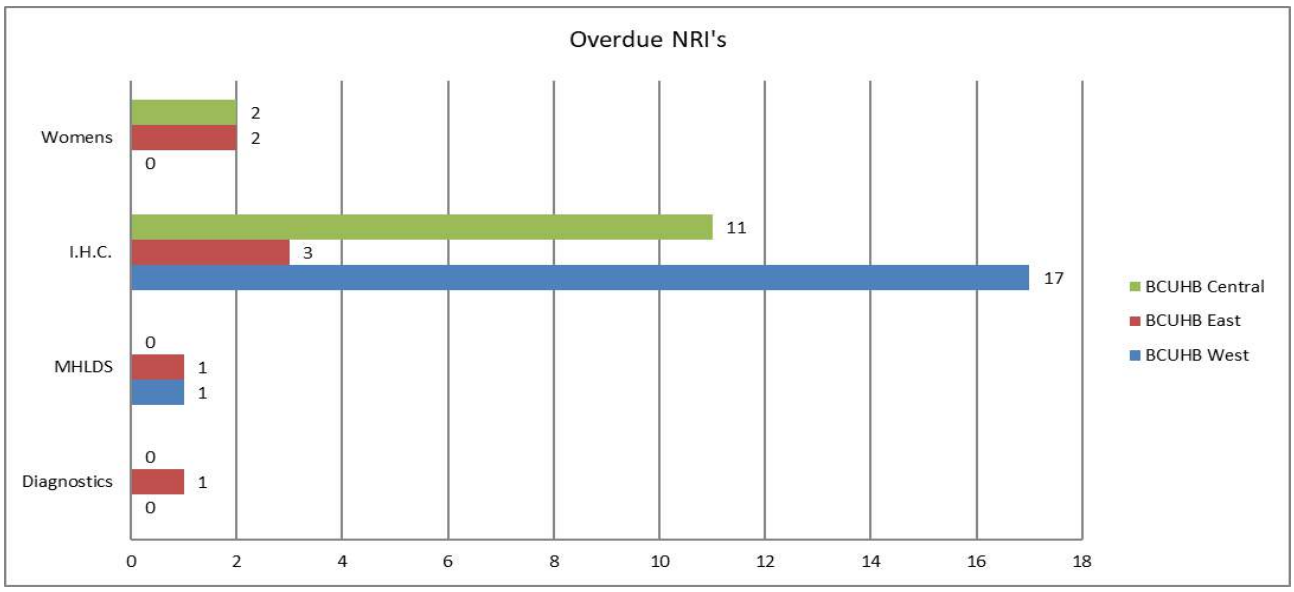
	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
Health Community West: YG	2	4	1	8	0	8	1	3	0	1	3	6	1	6	44
Health Community West: Primary and Community	0	1	1	1	0	3	2	0	0	1	2	0	0	2	13
Health Community Central: YGC	2	3	3	6	8	4	5	2	6	4	3	3	3	1	53
Health Community Central: Primary and Community	0	3	0	1	3	1	0	0	1	0	0	1	2	2	14
Health Community East: WMH	0	6	4	0	0	5	0	1	1	1	2	0	3	2	25
Health Community East: Primary and Community	0	2	1	1	0	0	0	0	1	1	0	1	0	0	7
Women's and Midwifery	0	2	3	0	0	1	0	0	1	2	1	1	0	0	11
Diagnostics and Clinical Support	1	0	0	0	0	0	0	1	0	0	0	0	0	0	2
Cancer Services	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2
Mental Health and Learning Disability	1	0	1	1	0	1	0	1	0	1	1	1	3	0	11
Support Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	6	21	15	18	12	23	8	8	10	11	12	13	12	13	182

There has been a gradual increase in reportable incidents since April 2022, with Health Community West, Ysbyty Gwynedd accounting for 7 of the 25 reportable incidents, followed by Health Community East, Wrexham Maelor Hospital with 5 reported incidents during the reporting period. However, the position remains lower than the previous year. The main themes continue to be falls, healthcare acquired pressure ulcers (HAPUs) and recognition and escalation of the deteriorating patient.

The NHS Wales Delivery Unit has stopped providing All-Wales comparative data.

In addition to the above mentioned nationally reportable incidents, there were 13 Early Warning Notifications (EWN) reported, 8 of which were in relation to healthcare associated infections (Clostridium difficile, Covid-19 outbreaks & Norovirus). The other notifications relate to incidents that may attract media attention.

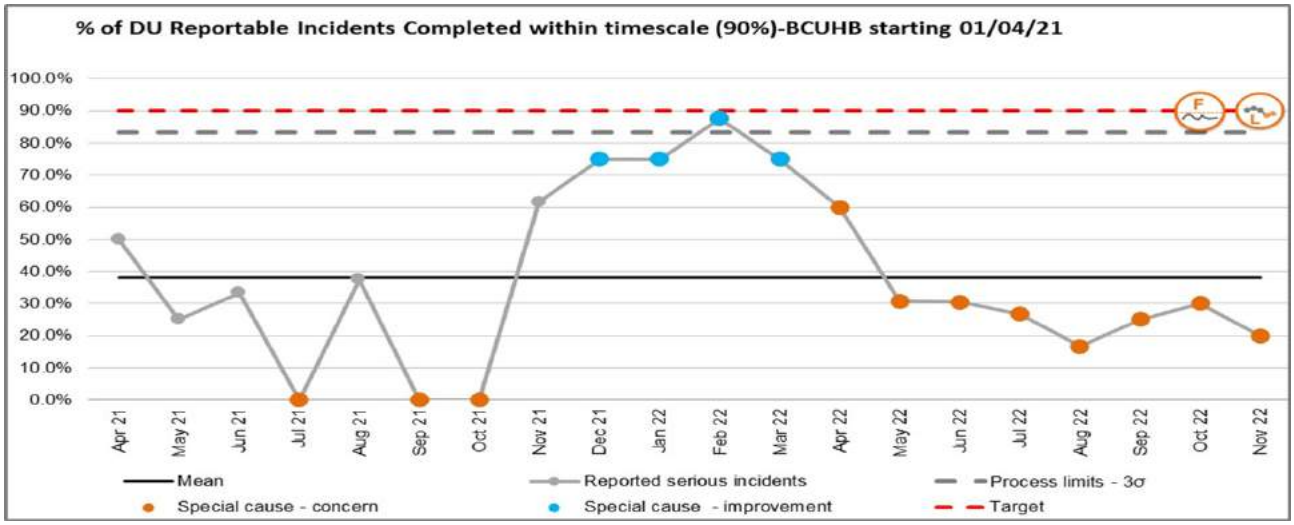
At the time of writing, the total number of national reportable incidents open is 76 of which 38 are overdue.



Overall investigation closure rate within timeframe was 30% in October, decreasing slightly to 20% in November. Weekly reports highlight the divisional performance.

Recognising the delays to full investigations, the Patient Safety Team continue to place particular focus on ensuring Make it Safe Rapid Reviews are completed so that early learning to improve safety is identified and implemented.

In November, the Patient Safety Team held a workshop to look at the historic overdue NRIs for Health Community, Central. During this workshop, 18 closure forms were submitted to the Delivery Unit. There will be a further workshop held to review the overdue NRIs for Health Community, West.



NATIONALLY REPORTED INCIDENTS (NRI) – LEARNING

There were 25 NRIs, for the two-month time period covered in this report. The NRIs recorded during this period can be broken down as follows

Grade 3 or above Health Acquired Pressure Ulcer n=7
Delay in recognition of deteriorating patient n=4
Falls n=5

Delay in diagnosis n=4
Suspected suicide (patient known to mental health services) n=2
Health Care Acquired Infection (resulting in death) n=1
Incident of unusual circumstance n=2

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 Cymru safety management system.

During October and November 10 RLP meetings took place into the most serious incidents.

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:

- A monthly Organisational Learning Forum – commencing in February 2023
- A weekly Harm Free Care Forum – commencing January 2023
- A new "lessons learned" on a page template
- A new monthly Quality Bulletin
- A new central Quality 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 (excluding Never Events)

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:

- Delay in recognition of deteriorating patient
- Healthcare acquired pressure ulcers (HAPU)
- Patient Falls

These three 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.

Never Events, whilst being a sub-set of Nationally Reportable Incidents, are detailed separately in a section below.

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

Recognition and escalation of deteriorating patient (to include delay/failure to monitor patient, failure to act on adverse symptoms and delay in diagnosis (n=8)

There have been eight incidents that were nationally reported during this period whereby recognition, escalation and treatment of a deteriorating patient has been delayed and subsequently resulted in severe harm or death. This is broken down as follows:

IHC Central (4), IHC West (2) and IHC East (2)

Over the last year, the following related incidents were reported as NRIs:

Recognition and escalation of deteriorating patient	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
YGC	0	1	2	4	2	1	3	2	3	1	0	0	1	1	21
WHM	1	0	0	0	0	2	0	0	0	0	1	0	2	0	7
YG	1	2	0	1	0	3	1	0	0	0	2	2	0	2	14
Central Area	0	0	0	0	1	0	0	0	0	0	0	0	1	1	3
Cancer Services	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Womens	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2
Total	2	3	2	5	3	7	4	2	3	1	4	2	4	4	48

Sepsis continues to contribute to mortality in the Health Board. Of the approximate 700 cases referred back from the Medical Examiner Service (MES) to the Health Board, 91 included sepsis either as a direct or contributory to mortality. The Health Board has invested in Acute Intervention Teams on the three acute sites to provide direct patient care for the deteriorating patient. The AITs also provide education and support to front line staff around recognition and treatment of sick patients, with a particular focus on NEWS and the Sepsis 6 bundle

The STEAR (Sepsis Triggers, Escalation and Antibiotic Stewardship Review) group was set up in May 2022 in response to the initial Academy of Medical Royal Colleges' (AoMRC) statement. It is a BCUHB wide group with membership from front line clinicians, AIT, microbiologists and antimicrobial pharmacists. They will oversee the transition to the new risk assessment tool for sepsis. They will work with the Clinical Effectiveness Team and clinical staff to determine a new data set to measure compliance with the new tool.

The benefits of the AoMRC statement are two fold (i) the sicker patients are focused on as a priority and (ii) allows healthcare professionals more time to investigate and consider best treatment for the patient with a lower NEWS. It is estimated this stratification of risk assessment could reduce the use of broad spectrum antibiotics by up to 75%.

The time-frame for agreement and roll out of the new risk assessment tool is anticipated for end of Q4. Data collection for the new Sepsis Tier 2 audit is anticipated to commence in Q1 of 2023/24. The results of the audit will be tracked via both the Clinical Effectivness Group and the STEAR Group which will inform any necessary improvement and / or education needs depending on results.

Falls (n=5)

Within the reporting period there were a total of 5 patient falls that resulted in severe/permanent harm and therefore met the criteria for national reporting. This is broken down as follows:

IHC West (3) and IHC Central (2)

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

Falls	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
YGC	1	1	1	2	4	2	0	0	1	2	1	1	1	0	17
WHM	0	1	3	0	0	2	0	1	1	2	0	0	0	0	10
YG	0	0	1	7	0	2	1	3	0	0	1	1	0	3	19
Central Area	0	0	0	0	2	1	0	0	0	0	0	0	1	0	4
East Area	0	0	0	0	0	0	0	0	2	1	0	0	0	0	3
West Area	0	0	0	1	0	3	1	0	0	0	0	0	0	0	5
MHLDS	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Cancer Services	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Total	1	2	6	10	6	11	2	4	4	5	2	2	2	3	60

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

- Staff oversight
- 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 10 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's Falls Improvement Group is detailed below:

The Falls Collaborative met on 23 November 2022 for a third masterclass to share progress to date following completion of Self-Assessment Tools that mirrors the new Falls Policy (NU06).

In addition, the collaborative confirmed principles of good practice/framework for each of the IHC Weekly Falls Reviews to ensure standard information is reviewed and sharing of lessons learned across all IHCs.

The Bedside Learning Model is now being led by Corporate Nursing and Health and Safety to support the wards with implementation during the current operational pressures. The Strategic Inpatient Falls Group are unable to provide the assurance that the bedside learning model is currently being implemented with pace due to operational, clinical and staffing pressures. There is a risk that the Health Board will not meet the expectations of the HSE in terms of risk assessment and interventions for every Adult Inpatient, should a revisit by HSE take place. More so, patients and staff are at risk of harm in addition to Health Board reputation.

A Health Board Task and Finish Group commenced to progress the funding, ordering and use of the equipment for acute and community hospitals to comply with associated Falls Guidance and to provide dignity of patients with a higher body wait who have fallen whilst as an inpatient. The Task and Finish Group Chair is the Deputy Executive Nurse Director of Nursing and membership includes all IHCs, Estates, Infection Prevention and Health and Safety.

Falls dashboards have been developed within the current Datix incident management system as an interim fix to support wards with access to their falls data easily. This is a temporary fix following the break in the data feed to the Health Board reporting mechanism Nursing Information Intelligence Portal (NIIP) since the implementation of the current version of Datix. It is still unclear when the national fix will be completed, the Health Board Informatics team are aware and involved in seeking a solution.

Grade 3 or above healthcare associated pressure ulcer (n=7)

Within the reporting period there were a total of 7 grade 3, grade 4 or ungradable healthcare associated pressure ulcers reported to the Delivery Unit. This is broken down as follows:

IHC East (3), IHC West (2) and IHC Central (2)

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

Avoidable HAPU	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Total
YGC	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1
WHM	0	5	0	0	0	1	1	0	0	1	0	0	1	2	11
YG	0	0	0	1	0	0	0	0	0	0	0	0	0	1	2
Central Area	0	2	1	1	2	0	0	1	1	0	0	1	1	1	11
East Area	0	2	0	0	0	2	0	0	0	0	0	1	0	0	5
West Area	0	1	0	1	0	0	0	0	0	0	2	0	0	1	5
Total	0	10	1	3	2	3	1	1	2	1	2	2	2	5	35

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.

An update from the Health Board's HAPU Improvement Group is detailed below:

The second HAPU Improvement Group was held on the 25 October 2022 with the first focused collaborative meeting on the 06 October 2022. The next workshop is scheduled for 06 December where each of the IHCs and MH will be presenting their first PDSA findings.

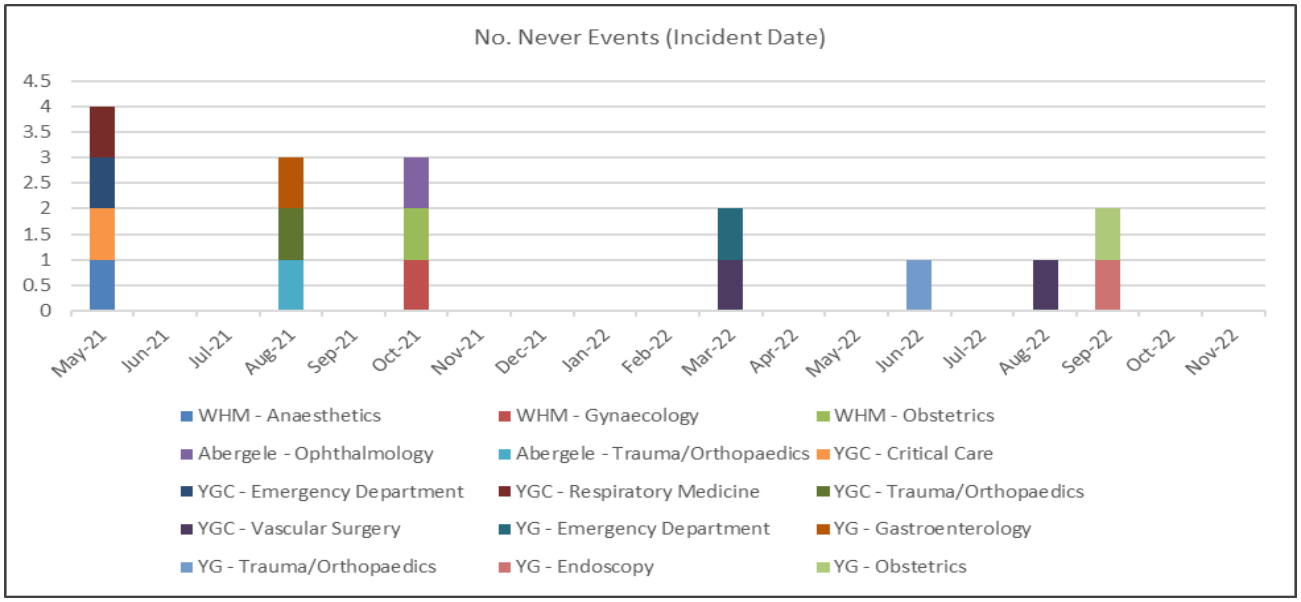
The overall aim of the collaborative is a 50% reduction in all reported Health Acquired Pressure Ulcers with 100% reduction in avoidable Healthcare Acquired Pressure Ulcers across BCUHB (hospital and community) by April 2024.

NEVER EVENTS

Within the current reporting period, zero new Never Events were reported.

In the current financial year, April to November 2022/23, four never events have been reported, compared to seven in the same timescale in 2021/22.

Twelve Never Events were reported in 2021/22 (with two subject to downgrades following investigation), compared to five in 2020/21 and six in the full year of 2019/20.



The primary theme (11 of 12 incidents from last year) is surgical safety.

In response, 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.*

The BCUHB Transformation and Improvement Directorate appointed a Quality Improvement Fellow specifically dedicated to theatres; the aim of this work is to support the teams in relation to consistently using the WHO checklist and addressing the causes of never events.

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 a number of positive quantifiable results:

- Zero WHO Checklist Datix incidents raised for 4 months (June/September 2022)
- 100% compliance with the Pre-Brief element for June/September 2022.
- 100% engagement with the Pre-Brief element for June/July 2022.
- 100% compliance with Sign In element for June/September 2022.
- 100% engagement with the Sign In element for June/September 2022.

The Time Out and Sign Out elements require further targeted testing across all teams. The recently ratified pan BCUHB LocSSIP 69 '5 Steps to Safer Surgery – The WHO Checklist' is soon to be shared across BCUHB theatres. Staff name and role boards are to be introduced within all YGC theatres imminently with this suggestion shared with East and Ophthalmic theatres.

Next steps / actions:

- November 2022, PDSA **cycle 1B**: Team will review feedback and re-test V2.7 in an elective (low risk) environment (16 – 22 November 2022). Re-auditing of team engagement will also run in parallel with the checklist test using the original audit tool. Feedback to be collated over a 5-day period.
- **PDSA cycle 1C**: Spread test to other elective theatres, re-audit, amendments applied and present to YGC HMT.
- Training, team sessions, posters, updates to HMT clinical leads, simulation sessions, training video.
- With full endorsement of the BCUHB Human Factors Faculty bespoke human factors training options are being explored with both AQuA and RJAH theatres.
- 10 November 2022, RJAH theatre visit to review WHO Checklist and Human Factors training programme.
- Continue to support theatre teams with surgical safety during observational audits.
- Requests sent to all three Theatre Managers regarding theatre never event incidents obtaining follow up assurance regarding their mitigation of potential future risks.

The QI Fellow is also supporting a request from the Director of Transformation and Improvement in relation to supporting a team with improvement methodology with regards to a potential NCEPOD theatre allocation for vascular emergencies at YGC. An initial meeting with key stakeholders has taken place and data is being collated for analysis.

The Associate Director of Quality and the Patient Safety Lead Manager are also linking in with the QI Fellow in relation to:

- Sharing of Never Event incidents pan BCUHB
- LocSSIPs library governance

- Human factors training bespoke for theatres – RJAH/AQuA
- BCUHB Perioperative Patient Safety Newsletter.

Staff annual leave, sickness, clinical demands continue to place restrictions on the speed of delivery of this pan BCUHB project – engagement from teams is a challenge in all areas.

Concerns have been raised with the LocSSIP implementation group and the Associate Director of Quality/Patient Safety Lead Manager in relation to the governance around this library. This has been taken up by a working group led by the Deputy Executive Medical Director who will be reviewing the content/version control and appropriateness of documents located within the BCUHB LocSSIPs Library.

ABH Ophthalmic Theatres have concerns around staffing which is impacting their WHO checklist compliance and engagement as well as other areas of patient safety. Am ophthalmic theatre matron is due to start in post shortly for support and escalation.

Closed Never Events

Retained foreign object –

In response to the investigation, the following actions are being taken forward:-

- Lessons learned around the importance of the World Health Organisation (WHO) Surgical Safety Checklist should be completed at the first available opportunity following clinical emergencies as per guidelines. Engagement from the whole surgical team is mandatory.
- Actions and learning following adverse incidents must be evidenced, documented and shared with the wider teams across the Health Board.
- Human Factors Training to be undertaken for all Theatre Staff and Maxillofacial Clinical staff.

Wrong site surgery –

In response to the investigation, the following actions are being taken forward:-

- Lessons learned around the importance of completing the World Health Organisation (WHO) Surgical Safety Checklist following surgery. As this is the single most important omission and would have acted as a safety net to prevent the incident if it had been undertaken.
- To roll out training and awareness program for all theatre staff which would include Human Factors and Civility Saves Lives programme.

Wrong implant prothesis –

In response to the investigation, the following actions are being taken forward:-

- The likelihood is that this Never Event would not have occurred should there have been more robust implant checks for compatibility in place. The use of large size

compatibility charts to be put up in all Orthopaedic Theatres and storage areas (Omnicell).
- All staff have been reminded of their responsibilities with regards to LocSIPP 68.
- Human factors training to take place on clinical governance days within the theatre department over the next six months.
- Staff awareness to be raised that ALL staff can speak-up for patient safety and that concerns can be instigated by any member of the multi-disciplinary team. Greater endorsement and support required to encourage this practice within the theatre department.

Wrong site surgery –

In response to the investigation, the following action is being taken forward:-

- Lessons learned shared amongst medical staff around the importance of visualisation of both tubes, if appropriate, to be made prior to surgery.

Open Never Event Investigations

The following Never Event investigations remain underway.

Incident date	Incident Description	Current status
20/08/2021	Wrong site surgery – ascetic drain	Rejected at ILP – more robust action plan required. The actionplan is being updated.
19/08/2022	Retained foreign object post procedure	Investigation ongoing and actively being chased.
16/09/2022	Wrong site surgery	Investigation ongoing.
23/09/2022	Retained foreign object post procedure	Investigation ongoing.

INDEPENDENT INVESTIGATIONS

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

Location	Incident	Update
CMHT (East) MHLD	Patient known to Community mental health team arrested on suspicion of murder	Action plan requires further work to improve and strengthen prior to re-submission to ILP.

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.
Womens services (West)	Maternal death	External Investigating Officer identified and review ongoing.

Additionally, a thematic review into a cluster of major obstetric haemorrhages was undertaken. The External MOH reports have been received and presented within the service. The anaesthetics department requested that an external anaesthetic review be completed as this was not undertaken as part of the initial external review, this is in progress.

NEAR MISS INCIDENTS

Near miss incidents can be a valuable source of learning. These are patient safety incidents that had the potential to cause harm, but on this occasion, harm was prevented.

TOP 10 Near Miss	Regional Services				West	Central	East	
	MHLDS	Women's	DSCSS	Cancer	HC	HC	HC	Total
Pressure ulcer category 2	0	0	0	0	9	2	30	41
Medical devices	0	0	0	0	1	21	0	22
Unstageable pressure ulcer	0	0	0	0	2	3	12	17
Slip, trip or fall	1	2	0	0	8	2	3	16
Suspected deep tissue injury	0	0	0	0	3	0	10	13
Treatment or procedure issues	0	1	0	0	1	8	0	13
Aggressive/threatening behaviour	12	0	0	0	0	0	1	13
Administration errors	0	0	0	0	2	4	4	12
Communication issues	1	0	1	1	2	3	2	10
Healthcare record	0	0	0	0	2	7	0	9
Total	14	3	2	1	30	50	62	166

The table above shows the ten most occurring “near miss” incidents by type of incident. Learning incidents occurs locally, but where themes are identified then work will be undertaken in response. The following case study demonstrates learning from near miss incidents.

Case study of learning from near misses –

Medication incidents related to insulin was identified as a near miss theme (with the potential for harm with any incident relating to insulin being high).

The latest National Diabetes Inpatient Audit (NaDIA) – 2019 highlighted that 4 out of 10 drug charts for insulin-treated inpatients had at least one medication error (40 per cent). The audit found that medication errors, prescription errors and insulin errors are more likely to occur in hospital settings where paper medication charts are used compared to using the electronic patient record. Glucose management errors are just as likely whichever system is utilised.

The pharmacy and medicines management and diabetic teams within each IHC have been working collaboratively to improve insulin safety, examples of work are summarised below:

1. **Variable Rate Insulin Use**

    - New BCU wide variable rate intravenous insulin chart has been developed and implemented.
    - In house training videos have been developed to accompany the use of the new chart (West IHC) and bespoke face to face training sessions scheduled for ED staff (Central IHC).
    - East IHC continue to use subcutaneous insulin sliding scales. Errors associated with its use have been the focus of the Harms Group 'Stop and Think' alerts and lessons learned disseminated to nursing teams.

2. **Promoting safer use of subcutaneous Insulin**

    - Insulin safety week campaign across BCU. The West diabetes and pharmacy team were nominated for the QiC Diabetes Excellence Awards and were finalists at the Sanofi excellence award ceremony in October.
    - Several resources developed and disseminated to nursing teams eg Pharmacy Fast Facts – Insulin Safety promoting the six rights to insulin administration, BCU Guideline to Prescribing Insulin on Admission to Hospital, as well as promoting the use of Diabetes UK videos on the safer use of insulin in hospitals and in community settings.
    - The BCU response to National Medication Safety week included a day to promote the safer use of insulin. This campaign featured virtual resources on Betsinet as well as face-to-face teaching via the medication safety stands set up at various community and acute hospital locations across BCU.

3. **Insulin Availability In acute clinical areas**

    - Ward stock lists and emergency cupboard stocks have been reviewed to ensure commonly used insulins are available in and out of working hours in clinical areas, especially emergency care and admission units.
    - Insulin syringe supplies kept in fridge along with insulin vials to minimise errors using incorrect devices (which could lead to never events).
    - Insulin posters displayed on fridges in clinical areas to minimise vial mis-selection.
    - Advice for prescribers for patients admitted to hospital when the usual insulin regime is not known.

Despite these initiatives, insulin errors continue to be reported. In the interim period before electronic prescribing is implemented, the Safer Medicines Steering Group is scoping the development of a BCU Insulin Administration and Monitoring Chart which may be helpful in reducing omissions and promote safer prescribing.

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.

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

Open Alerts

Reference	Title	Applicable to	Type	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. Deputy Executive MD now providing leadership to progress completion. Expected completion is in February 2023.

Closed Alerts

No alerts have been closed for the time period

LITIGATION

During this bi-monthly period of October and November 2022, 50 claims or potential claims were received against the Health Board. Of these, 43 related to clinical negligence and 7 related to personal injury.

Whilst the numbers have fluctuated a little throughout the bi-monthly periods, it is anticipated by NHS Wales Legal and Risk Services (L&R) (the Health Board's solicitors) that claims will rise significantly due to the direct and indirect effects of the Covid-19 pandemic. It is believed the figures will increase as the Health Board begins to deal with the effects of cancelled procedures and appointments.

During the bi-monthly period, 19 claims were closed. Of these, 22 related to clinical negligence and 4 related to personal injury. The total costs for the total closed claims in this period amounted to £2,194,986.57 before reimbursement from the Welsh Risk Pool.

The most significant claims related to:

a. Claim relates to complication of surgery & informed consent. Failure to use most appropriate technique whilst inserting the visiport during laparoscopic surgery resulting in damage to the common iliac artery and vein at the pelvic brim. (2018) (£609,945)

Learning:

- Review of consent policy and consider incorporating specific GMC guidance relating to serious adverse outcomes and undertake audit of consent practice.
- Review patient information leaflets given in pre-op assessment clinics.
- Review surgical techniques during laparoscopic procedures to ensure surgeons are using the safest possible technique based on available literature.

b. The claim relates to gynaecological treatment received. Failure to obtain informed consent and to mention alternative management options. Undertaking an operation different to that listed on the consent form. (2014) (£614,691.64)

Learning:

- Procedure specific consent forms have been developed and implemented for urogynaecological procedures. This will ensure that only the operation consented for is completed.
- A lessons learned/Themes & Trends report is being developed by the Women's Directorate, which will be shared at the Women's Quality, Safety & Experience sub-group and widely disseminated. Learning from claims will inform a part of this report.
- A Urogynaecology MDT is now in place. All surgical management of incontinence e.g. TVT are now discussed and agreed at MDT.
- Incident shared at the Women's Quality, Safety & Experience sub-group in January 2021, to ensure shared learning across North Wales.

c. Claim relates to a delay in diagnosing viral encephalitis resulting in brain injury. (2010) (£222,798.12)

Learning:

- Summary on viral encephalitis to be prepared and shared with colleagues suggesting that if GPs can't be sure what they are dealing with, to send the patient to hospital.
- Sepsis Bundle introduced and practice has changed to ensure antibiotics and antiviral medication administered in a timely way.
- Research project undertaken called ARK that supports a 72 hour review of antibiotics to promote good prescribing practice.

d. Claim relates to a failure to arrange an x-ray, or to seek an orthopaedic opinion when the patient re-attended ED (2014) (£182,910.66)

Learning:

- Case was presented at the Mortality and Morbidity meeting (as an event for note) in November 2014
- Case was used as a teaching case for the ED staff.

e. Failure to remove gallstones in a timely manner leading to pancreatitis and death. (2014) (£155,677.80)

Learning:

- There has been a change in triaging, in that for every patient of concern, consultants are asked to document on the referral the maximum time the patient can wait before being seen. E.g. urgent – within 4 weeks.
- Booking centres now use a centralised printing and sending system called Neopost.

f. Claim relates to a sudden death from DVT within 48 hours of discharge from hospital. Failure to consider pulmonary embolism as a differential diagnosis (2017) (£85,400.11)

Learning:

- Training is provided to FY1 and FY2 on their introduction once a year, and the thromboprophylaxis Clinical Nurse Specialist (CNS) provides bi-monthly training sessions on VTE and thromboprophylaxis. The CNS also provides training at other departments study days. These sessions are open to medical, nursing, ANP and pharmacy staff. An e-learning module is currently being developed in order to reach more staff.
- Audit regarding thromboprophylaxis consideration - Presented at Grand Round.
- A management of acute pulmonary embolism pathway was produced. This was promoted and training provided to all medical acute units including SDEC and ED and AMU.

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

Personal injury claims savings due to discontinued or favourable settlements for this period are £151,804.01. 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 Legal Services Team 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 October and November 2022, 89 new inquests or requests for information from the coroner were received from the Coroners in North Wales. This is a significant increase on the previous two months.

52 inquests were concluded between during October and November 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.

Some examples of learning related to Inquests during this period:

a. <u>Deterioration of patient (2021)</u>

Learning:

- Further training given to the District Nursing Team and staff members within the Ruthin Team on the importance of good pressure ulcer identification, management and documentation.
- Ward manager will instigate spot checks on documentation to improve handover between nurses at shift change to ensure all outstanding tasks are handed over and this is clearly documented within the ward safety brief / SBAR handover document.
- Patients identified with an existing pressure wound or at risk of a Health Acquired Pressure Ulcer (HAPU) will be discussed with the nurse in charge every 2 hours as part of the safety huddles; this gives the opportunity for escalation if pressure-relieving equipment is available.

a. Deterioration of patient (2020)

Learning:

- The Governor and Head of Healthcare at HMP Berwyn will ensure that 'extremely clinically vulnerable' prisoners required to shield during a pandemic are able to reduce person-to-person contact and that their medication is dispensed safely at their cell door.
- Regular infection prevention audits to be completed and issues escalated to cleaning contractors.
- HMP Berwyn correctly identified an unsafe transfer of care from HMP Swaleside. All such inappropriate transfers of care should be escalated to the medical director responsible for care at both prisons to reduce incidence, and a report outlining lessons learned to prevent similar should be produced.
- The Coroner commented that the infection control measures within the prison were approached conscientiously and were evolving to reflect national guidance. The healthcare provision was of an excellent standard.

b. Self-discharge from ED (2019)

Learning:

- Ensure the mental capacity assessment is completed on the patients with irregular discharge and escalate to most senior clinician on shift if lacks capacity
- If the patient deemed to have mental capacity, the staff should encourage patient to sign self-discharge section of ED clerking booklet
- Ensure staff are aware of missing person's protocol to ensure initiated as required
- Ensure all staff groups are compliant with mental Capacity Training (Level 1 and Level 2)

There are currently 49 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, one Regulation 28 (Prevention of Future Death) Report was issued by HM Coroner to the Health Board. This related to the pace of improvement work for intra-hospital transfers. At the time of writing, the Health Board response was being finalised.

HM Coroner raised a concern following an Inquest and asked for further information prior to making a decision on issuing a PFD report. The Health Board has been asked to provide this information within 28 days. This concern related to whether the Health Board audited an externals service provider. The Health Board does and at the time of writing, the Health Board response was being finalised.

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.

Focused work is underway to address the issue of overdue and delayed investigation reports. The primary sites of concern are Ysbyty Glan Clwyd and Ysbyty Gwynedd and the Patient Safety Team are working with the new IHC Teams to address this issue promptly.

Of note, the Committee's attention is drawn to the overdue Safety Alert and new Regulation 28 Notice and are advised of the work underway to address both.

The QSE Committee is asked to note the report.

Teitl adroddiad: ***Report title:***	Patient and Carer Experience Report
Adrodd i: ***Report to:***	Quality Safety and Experience Committee (QSE)
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023
Crynodeb Gweithredol: ***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.
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy 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

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:

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.

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Considerations in this report cover compliance with the Putting Things Right Regulations and Ombudsman requirements.
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?***	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)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
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) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Patient and Carer Experience Report – August 2022 - November 2022	

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

Patient and Carer Experience

Report to the QSE Committee

August-November 2022

Patient and Carer Experience Report August 2022 – September 2022

1. INTRODUCTION

1.1 Patient and carer experience is what 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:

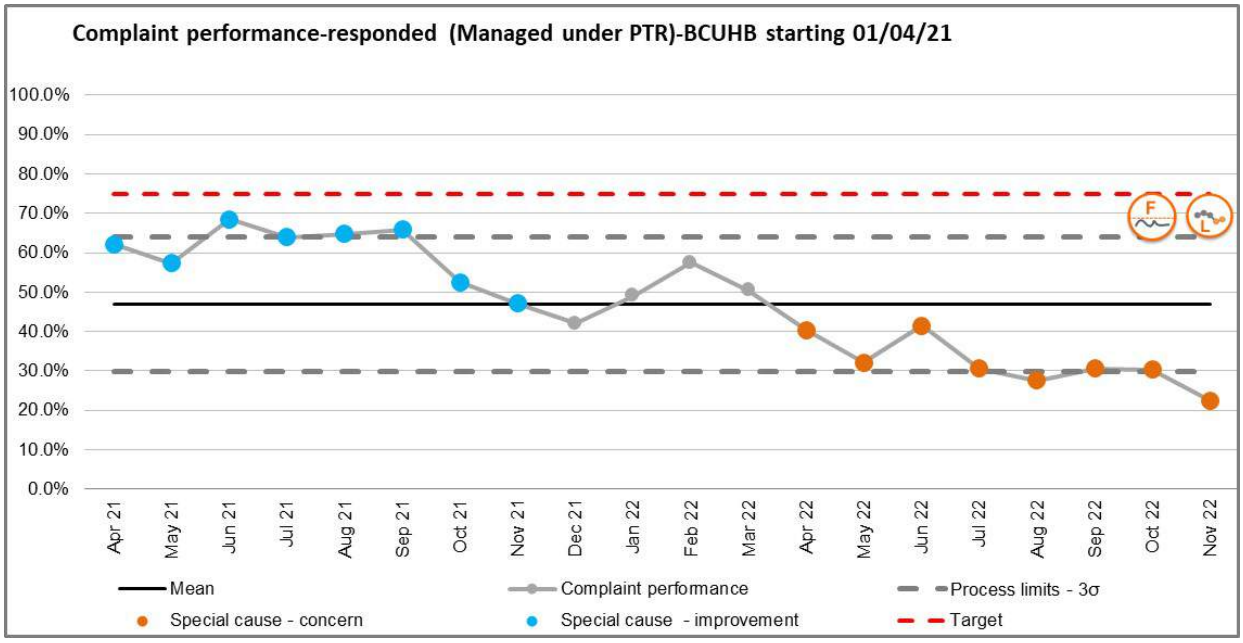
- NHS Delivery Framework 2019/2020 (NHS Wales, April 2019);
- Listening and Learning from Feedback – A Framework for Assuring Service User Experience (Welsh Government, 2015);
- Healthcare Standards for Wales (Welsh Government, 2015)
- Wellbeing of Future Generations (Wales) Act 2014;
- Social Services and Wellbeing (Wales) Act 2014;
- Parliamentary Review of Health & Social Care in Wales (Welsh Assembly, 2018)

2. COMPLAINTS - PERFORMANCE

2.1 During the months of August 2022 to November 2022, 957 complaints were received by the Health Board. 697 of those were complaints managed under the Putting Things Right Regulations (PTR). 279 were initially classified as Early Resolutions and 44 of these were later upgraded to being managed under the PTR as the services involved did not manage them to resolution within 2 working days.

2.2 The majority of the complaints related to Secondary Care Services, with 77% of the complaints managed under PTR. The themes related to clinical treatment and assessments, poor communication and waiting times. Other recurring themes were in relation to patient discharge from hospitals, prescribing and treatments not providing the expected outcomes.

2.3 At the end of November 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 21%. This is shown below in figure 1 below. The performance level has dropped due to the number of new complaints received during the period in addition to managing the backlog position. In addition, work pressures within services has compromised performance due to capacity.



2.4 Integral to the overdue complaints recovery plan, constructive discussions have taken place with Directors of Nursing and Heads of Nursing to implement a robust plan to manage the overdue complaint backlog alongside trajectories. Resolving the backlog position will enable improved timeliness and achievement of the 30-day target. The Patient and Carer Experience Department are proactively engaging with services to establish how we can resolve enquiries at the earliest opportunity with a focus on extrapolating themes and trends identifying the services receiving the highest number of complaints. This will identify training opportunities and performance management issues. The Complaints Team are supporting the management of early resolutions which require a response within two working days, proactive engagement and the assurance that the relevant leads within services are identified will contribute to a reduction of the number of early resolutions upgrading to being managed under PTR.

2.5 There was a decrease in the number of overdue complaints during this period, with a decrease from 467 complaints open in September 2022 to 342 complaints open at the end of November 2022.

2.6 There are no legacy cases remaining open (i.e. those opened before the new complaints process was introduced in April 2021). This 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 at weekly redress clinics and a collaborative approach supported the closure of the remaining legacy responses.

2.7 The team continue to work with services to provide accurate and detailed performance data on a weekly basis with a new complaint management approach adopted via ‘rapid resolution workshops’ to resolve the backlog of overdue complaints. In addition, the Complaints Team are continuously cleansing the data to ensure that all complaints are closed where consent is not obtained after thirty days, and any complaints relating to a patient safety incident are transferred to the incident team for investigation. The main objective is to improve performance to achieve the Welsh Government’s Complaints Key Performance Indicators (KPIs) and improve patient safety and care, ensuring that action plans are implemented and positive changes are made to provide support to services with complaint resolution.

2.8 During September and October 100% of complaints, and during November 2022 98.51% of complaints (198 out of 201 complaints), were acknowledged within 2 working days, in accordance with the PTR timescales. The Complaints Team continue to review processes to identify opportunities to improve and maintain key performance indicators.

2.9 The common themes identified for the early resolutions for the period were particularly in relation to:

- Adult Community Mental Health Services – lack of communication, changes in appointments, lack of support for mental health condition(s).
- General Practice – Difficulties in obtaining regular prescribed medication and/or new medication.
- Emergency Medicine – Lengthy waits, conditions of facilities, staff attitude, lack of staff
- General Surgery – Lack of/poor communication, waiting times for surgery
- Community Dental – Difficulties accessing emergency dental care.

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 three subjects most frequently identified from complaints received during the reporting period were:

- Clinical treatment/assessment (across all services)
- Communication issues including language (across all services)
- Appointments (across all services)

3.4 **Case Studies:**

(i) Case study: ID3717

Complaint summary	Investigation	Outcome/learning/actions following investigation
A patient was unhappy with the care he received whilst an inpatient at YG, reported he was left without refreshments, became dehydrated, no food options were given on the ward and the standard of food was poor, especially vegetarian food. They stated that medication was not given	As there are no tables in the Acute Medical Admissions Unit, a self-service tea/coffee machine and water fountain is in place for patients to help themselves to hot drinks and cold water. Hot and cold drinks are offered by staff alongside this facility.	The catering department provide nutritionally balanced meals and offer a range of vegetarian options to inpatients in order to provide all patients with a balanced diet. Water in jugs are provided to all inpatients and these are

in a timely manner and was also unhappy with the attitude of the medical and nursing staff.	The patient was transferred to a ward. Three meals are provided per day to inpatients, and when patients request an additional fourth meal (a sandwich in this case) staff will try to source one where possible.	refilled regularly, along with frequent hot drinks rounds. The action from this complaint is that ward staff will welcome new patients onto the ward with an orientation to the location of water, drinks and the toilets. Staff will ensure refreshment are offered in future. Special dietary requirements are recorded on the menu card when ordering from the Catering Department.

(ii) Case study: ID 39886 (upheld by the Ombudsman in 2022)

Complaint summary	Investigation	Outcome/learning/actions following investigation
A relative complained that the Health Board failed to take appropriate action to minimise the risk of their mother falling while she was mobilising to the toilet in hospital and that it did not conduct an appropriate investigation into a fall. The relative also complained that the Health Board failed to ensure that a physiotherapy assessment and care plan was appropriate, and that the frequency and regularity of her mother's community-based physiotherapy was inadequate to meet the needs.	Whilst it was difficult to determine with any certainty the exact sequence of events relating to the fall, it did not appear that the Health Board had taken all appropriate actions to secure the patient's safety when mobilising to the toilet. There was insufficient evidence to demonstrate that staff were aware the patient required 2 people to help her mobilise. There were discrepancies and inconsistencies throughout the records and the Health Board's investigation meant that the findings about what happened were irreconcilable with the available evidence. The Ombudsman found that, despite dispute regarding the detail of the assessment and care plan, the documented care plan was clinically relevant and appropriate to meet the patient's needs.	Lessons Learned posters have been developed and were circulated to staff stating the following: All staff on the 2 wards involved to review **all** inpatient risk assessments and update these immediately to identify patient risks and what can be done to keep our patients safe from harm. All patient risks must be reviewed and updated on a minimum weekly basis. Where a patients presentation begins to change (i.e. deteriorate) the risk assessments must be reviewed and updated as necessary. All Health Care Assistants must attend and receive a patient safety brief before commending their shift. A falls audit will monitor compliance with the above.

	Whilst the number of physiotherapy sessions provided in a 5 month period was less than had been documented or agreed, there was no clinical detriment to the patient her progress was comparable to her ability when she had been receiving physiotherapy more frequently. Whilst the evidence supported that the patient and relative were appropriately engaged with the care plan and involved in relevant decisions, there were failures to explicitly clarify the care plan and to explain the reasons why the number of sessions provided were fewer than they had been expecting.	

(iii) Case study: ID 2246

Complaint summary	Investigation	Outcome/learning/actions following investigation
The patient was unhappy with the care and treatment he received when attending the Emergency Department and self-discharged.	The patient was seen and underwent a CT scan, which showed bleeding in the space surrounding the brain. Advice was sought from the closest trauma centre (UHNM) who recommended that the patient was admitted locally and observe for 48 hours. There was some debate over the management of the patient's care between teams. The patient continued to have observations performed whilst staff tried to get the patient's care taken over by the appropriate consultant. The patient eventually self-discharged against medical advice.	The delay in accepting the referral was due to hospital referral pathway not being followed. The pathway for head injury patients was under review and this led to some confusion between the Medicine and Surgical Directorates. The new process for referral has been communicated to the speciality teams and remains under review.

(iv) Case study: ID3929

Complaint summary	Investigation	Outcome/learning/actions following investigation
The patient was awaiting parathyroid surgery in Cardiff and his parathyroid imaging coincidentally demonstrated the presence of a right-sided thyroid nodule. The Cardiff surgeons requested a fine needle aspirate (FNA) of his thyroid nodule as if it was malignant (cancerous) they would undertake a right sided hemi-thyroidectomy along with parathyroid surgery. The patient attended the Radiology department for an ultrasound guided needle biopsy of a right sided thyroid nodule. The patient has been informed by his Clinician that the FNA sample has either been missed or inadvertently disposed of by the Cellular Pathology laboratory as no result has been received. The patient reports that due to this loss of sample, his ongoing treatment has been delayed along with potential surgery, with these events having severe detrimental effect on his mental health. A further FNA has been booked. The patient would like to know how his biopsy sample/results could have been lost.	The laboratory standard operating procedure for processing of FNA samples would include dividing the sample to produce a microscopic slide and separate solid cellular block. The microscopic slide would be made from applying a small amount of the FNA sample to a glass slide which is then stained with special chemical stains to allow visualisation of the cellular material. The rest of the sample would be then be committed to the formation of a solid paraffin block which is suitable for thin sections to be removed for staining, and microscopic study. Both methods allow for the visualisation of cells via a microscope in order to identify any abnormal changes in the cells. On this occasion, the microscopic slide was not created and the entirety of the sample was instead made into a paraffin block. The staff member had made the assumption that the slide had already been made, so processed the whole sample to a paraffin block. This incorrect assumption was concluded to be caused by a breakdown in communication between staff members.	The investigation has led us to recognise that the laboratory requires a fully documented handover procedure for improved staff to staff communications. Following this complaint, a handover sheet for staff to communicate to colleagues any outstanding procedures at the end of the day has been introduced.

(v) Case study: ID1185

Complaint summary	Investigation	Outcome/learning/actions following investigation
Following a stroke a patient was admitted to hospital. He was unhappy that he was transferred to his local hospital (Stoke) by taxi without a medically trained escort for a lengthy journey.	The Welsh Ambulance Service were contacted and an ambulance was booked to transport the patient to the Royal Stoke Hospital. However, due to demands on the ambulance service, they contacted the ward and asked if the patient could be transferred by taxi. Tthe ward agreed and the ambulance was cancelled.	The Ward Manager has discussed with ward staff the importance of booking appropriate transport, following risk assessment, when transferring patients to other hospitals. The Ward Manager will ensure ward staff communicate regularly with family members.

4 COVID-19

4.1 The Health Board continues to adhere to the Welsh Government National Nosocomial Covid Programme (NNCP) framework 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 objectives enable identification of potential harm and learning in relation to nosocomial transmission of Covid-19.

4.3 The Health Board are in continuous contact with the NHS Wales Delivery Unit National Nosocomial Covid-19 Programme (NNCP), working closely 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.

4.4 A scrutiny panel has been established to decide, based on the findings of an investigation and broader triangulation of information to ascertain:

- The care received by a patient was reasonable at the time.
- 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, was it reasonable for this not to have been done?
- If the case is suitable to be considered under the Putting Things Right Regulations.

4.5 The scrutiny panel report quarterly to the Executive Team, and through the established organisational Health Board reporting mechanisms.

4.6 Newly appointed COVID 19 PALS Officers are now in place and will offer 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 in line with Welsh Government requirements. The contact information is promoted on the BCUHB internal and external internet site. The purpose of the dedicated five-day single point of access is to ensure a consistent, dedicated and access of support for patients, carers and families affected by nosocomial Covid-19

4.7 Communication has been issued via letters to families from Wave 1 and PALS Officers are in place to take engage with families and offer support and signposting to relevant support needed.

4.8 National learning is key and will be extracted from investigations and information presented as an action/improvement plan in preparation for any future waves, is currently by way of circulating information with infection prevention and control colleagues via Safe Care Harm Free work stream, Learning from Mortality Panel and Clinical Effectiveness Group. The work programme requires support from all Health Communities with easily accessible information to support the conclusion of the investigations

4.10 Engagement has been made with BCUHB Bereavement Quality Group and links have been formed with Palliative Care Nurses, Ward Sisters, and PALS across West, Central and East. Engagement with the Community Health Council and reviewing National Learning and sharing good practice will continue and will include the sharing of family and patient stories

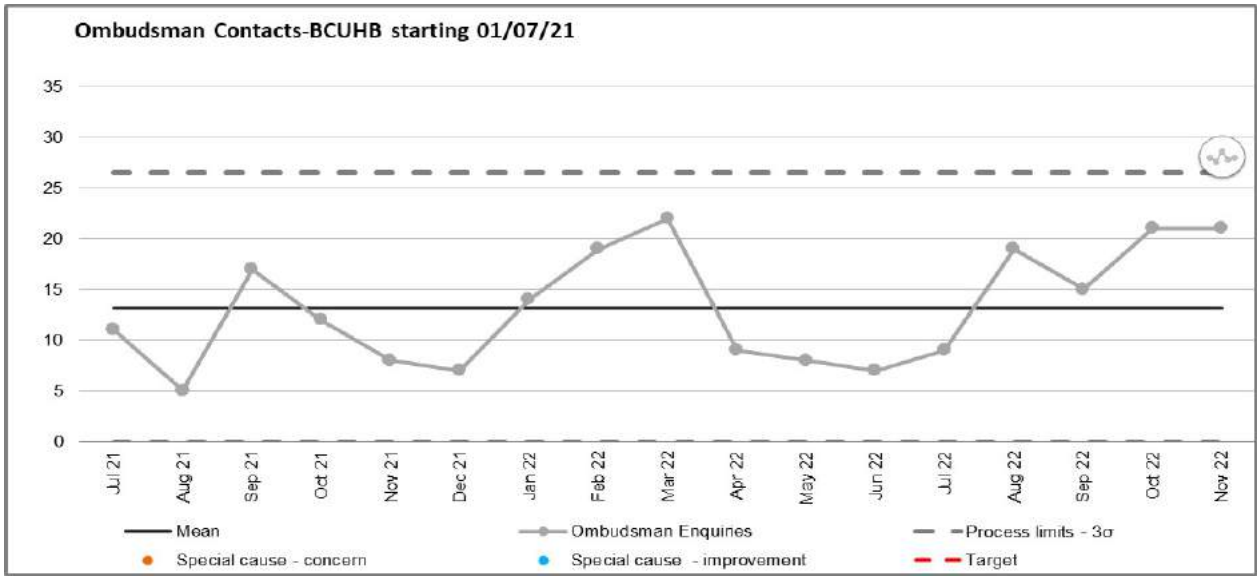
4.11 Developments are in progress with the Once for Wales CIVICA patient and family feedback survey; we will work with the Delivery Unit to ensure consistency within the questions needed.

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 was issued on 9th August and was received via the Quality, Safety and Experience Committee on 6th September under the leadership of the Vice Chair. A letter is response to the Annual Letter was submitted to the Ombudsman on 28th September 2022.

5.3 During the period under review (4 months, August to November 2022), the Ombudsman contacted the Health Board regarding 76 new concerns, compared to 33 in the previous 4 month period.



5.4 During the period under review (4 months) the Health Board has received notification that a further 14 new complaints which will be fully investigated by the Ombudsman, compared to 17 in the prior 4 month period.

5.5 The Health Board currently has 97 Ombudsman Investigations ongoing which is a slight reduction since the last period when 102 were reported. These figures are unprecedented and the highest numbers ever recorded.

5.6 Across the Health Board, there are currently 28 cases within the West, 32 cases within Central and 37 cases within East.

5.7 Rather than carry out a full investigation, the Ombudsman will often ask the Health Board to agree to an early resolution proposal. These numbers also remain high with 14 cases currently being dealt with across the Health Board.

5.8 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 to discuss and share their own compliance report used internally and to review the Health Board current position. Meetings were held on 18th August, 12th September, 13th October and 8th November 2022. PSOW have previously stressed that their own Investigators do not always update their systems and the numbers of cases they report where compliance has not been met may be higher than the true record. This is proving to be a useful monthly exercise with the numbers of cases PSOW believe to be overdue reducing. Future meetings will now be held less frequently as PSOW are satisfied with the Health Boards compliance.

5.9 **Ombudsman Public Interest Report**

One Public Interest Report was received on 21st September 2022 and issued under s.23 of the Public Services Ombudsman (Wales) Act 2019. The complaint related to the care and management following a referral to an NHS Hospital Trust in England (Walton Trust) which was commissioned by the Health Board to provide care/treatment. (The Health Board having commissioned the care from the Trust, remained responsible for the monitoring and oversight of the care which the Trust provided). The Consultant Neurologist based at the Trust failed to diagnose the patient's multiple sclerosis ("MS" -

a condition which affects the brain and the spinal cord) between 18 May 2018 and 19 September 2019. The Health Board should have explored a local referral option before sending the patient to the Trust. The complaint also related to the complaint responses received from both the Trust and the Health Board which were not robust and were inaccurate. An action plan was developed and monitored to ensure all recommendations were implemented in time for the Ombudsman's deadline in October 2022.

5.10 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 13 cases under review for Redress. The Health Boards Investigation Report template has now been amended to ensure breach of duty and qualifying liability are considered where necessary.

5.11 Specialties being monitored for increased numbers of complaints being investigated by the Ombudsman are the following:

- GP surgeries have 12 cases being investigated by the Ombudsman;
- Mental health have 10 cases being investigated;
- Continuing Health Care Team have 7 cases;
- Obstetrics & Gynaecology have 6 cases;
- Emergency Departments have 4 cases;
- Urology numbers have reduced to 3 cases;
- HMP Berwyn have reduced to 2 ongoing investigations.

5.12 The Ombudsman released their new format All-Wales Complaints Standards Data - April to September 2022 – allowing comparison across Health Boards. This is a new report, based on new format data from the Once for Wales Datix system launched in April 2022. As such, there may still variation in data quality across Wales.

	Population	Complaints Received	Complaints Received per 1000 residents (adjusted)	Complaints Closed	Within 30 days %	Referred to Public Services Ombudsman for	Referred %	PSOW Cases Closed	PSOW Intervened %	Early resolution %	PSOW Upheld%
Aneurin Bevan University Health Board	591,225	1,656	5.60	1,568	80.29%	83	5.29%	70	22.86%	10.00%	10.00%
Betsi Cadwaladr University Health Board	698,369	1,786	5.11	1,473	61.98%	114	7.74%	102	35.29%	23.53%	9.80%
Cardiff and Vale University Health Board	496,413	2,509	10.11	2,357	83.03%	65	2.76%	61	19.67%	14.75%	4.92%
Cwm Taf Morgannwg University Health Board	445,190	1,676	7.53	1,558	87.61%	77	4.94%	65	16.92%	9.23%	7.69%
Hywel Dda University Health Board	385,615	1,269	6.58	1,164	75.00%	43	3.69%	45	51.11%	37.78%	13.33%
Powys Teaching Health Board	132,447	76	1.15	82	40.24%	15	18.29%	13	23.08%	15.38%	0.00%
Swansea Bay University Health Board	389,372	1,066	5.48	986	65.82%	68	6.90%	57	26.32%	15.79%	8.77%
Velindre University NHS Trust	-	84	-	73	98.63%	3	4.11%	3	100.00%	33.33%	33.33%
Welsh Ambulance Services NHS Trust	-	619	-	289	57.79%	22	7.61%	26	15.38%	3.85%	3.85%
										-	
Wales	3,138,631	10,741	6.84	9,704	75.89%	490	5.05%	413	28.09%	17.92%	8.72%

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 August to November 2022, 39 cases were concluded which involved Redress:

- 14 offers of financial compensation as redress were made totalling £69750. 9 offers of financial redress were accepted totalling £66250.
- 1 proceeded to become a clinical negligence claim
- 2 were advised following an interim response (Reg 26) accepting there was a breach of duty, that there was no Qualifying Liability (Reg 33).
- 17 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

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; both paper and digital 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 From August 2022 to September 2022, PALS dealt with 2278 enquiries. Below are the top three enquiry themes:

- Communication (negative)
- Assisting Service users (negative)
- Delay in appointment (negative)

To help improve communication and staff assisting service users, the Patient and Carer Experience Team are delivering a series of Patient and Carer Experience Training sessions across Integrated Health Communities. Within a two-month period, 17 training sessions were delivered to staff in the Central Integrated Health Community. The training includes effective communication, empowering staff to resolve issues locally to encourage early resolution of complaints and raising awareness of the role of PALS.

8.3 From August 2022 to September 2022, 4,741 patient feedback surveys were completed. Overall 89% of patients who completed the survey were satisfied and felt they were listened to. The Patient and Carer Experience Team are re-launching the Civica All Wales Feedback system with both staff and patients, this includes SMS texting to patients who have attended an outpatient appointment, recently discharged or attended an Emergency Department using the All Wales Friends and Family Test (FFT) feedback survey.

8.4 Patient and Carer feedback kiosks have been installed in the waiting areas of Minor Injury Units (MIU) across North Wales. The feedback kiosk give patients and carers the opportunity to complete an all Wales Patient Feedback Survey through Civica whilst they are waiting for treatment. In November 2022, the MIU at Llandudno Hospital received 86 feedback surveys completed through the kiosk, of which 99% of respondents who completed the survey felt they were listened to and got assistance when needed. The Patient and Carer Experience Team will continue to roll out feedback kiosks across outpatient areas and Emergency Departments across the Health Board.

8.5 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 or 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:

> “I cannot fault the quality of care I have received; my needs have always been met up to a high standard. Everything I asked for was never too much for staff. They answered the call bell straight away and made me feel safe within their care”. Glyder Ward, Ysbyty Gwynedd

8.6 PALS are supporting the collation of patient and carer feedback for the National Audit of Dementia to find out patients with dementia experience of hospital admission. The Patient and Carer Experience Team are supporting the re-launch of the Language Choice Scheme and Butterfly Scheme across BCUHB.

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. BCUHB were a finalist at the Patient Experience Network National Awards in Birmingham on the 28th September 2022 for Effective Partnership Working in Patient Centred Care award category. On the 28th October 2022, BCUHB won an NHS Wales award for Empowering People to Co-produce their Care for the Long Covid Service. This national recognition confirms the importance of patient and carer involvement in co-producing BCUHB services.

8.8 The Patient and Carer Experience Team continue to support services ensuring the patient and carer voice is listened to when setting up or re-designing services. A series of patient and carer stories were presented to staff, patients, carers and stakeholders at prostate cancer pathway redesign workshops and at an Older Person Mental Health Dementia re-design workshop.

8.9 The Patient Advice Liaison Service are supporting the Mental Health Division to increase CIVICA patient feedback usage across the Division by providing training to divisional staff and have provided electronic equipment to capture surveys. PALS have supported a 4-week period of weekly patient forum meetings establishing relationships with patients and encouraging feedback at the Heddfan Unit. Introductory patient and care experience meetings with ward managers at both Heddfan, Ablett, NWAS and Hergest Unit have taken place.

8.10 The Patient and Carer Experience Team continue to promote the role of the PALS service to support both patients, carers and staff across BCUHB. The Patient and Carer Experience Lead Manager delivered a patient and carer awareness session at BCUHB Geriatric Study Day at Ysbyty Glan Clwyd and a PALS awareness raising session for the Transformation Team Development Session.

8.11 PALS continue to support Ysbyty Glan Clwyd and Wrexham Maelor Hospital Emergency Departments (ED) by undertaking weekly Care2Share discovery interviews with patients and carers in ED. Real time feedback from patients and carers is passed to relevant managers to help influence service improvements. Feedback from patients helped inform a bid for Welsh Government funding to improve Emergency Department waiting areas. BCUHB were successful in securing £418,000 Welsh Government across the three Emergency Departments funding included the purchase of larger TV screens to improve patients accessibility to information displayed, improvement to seats and lighting, equipment for a Children's waiting area and mobile phone charging stations.

8.12 In partnership with the Deep Vein Thrombosis Service (DVT) in the Central Integrated Health Community, the Patient and Carer Experience Team spoke to 16 patients to capture their experience of the current DVT service in particular around communication and service follow up. This feedback has helped inform changes to the service. Further service feedback is planned to capture patients experience since the changes to the service have been made.

8.13 The Patient and Carer Experience Team in partnership with other BCUHB Services were involved in submitting an application to the Welsh SBRI Innovation Accelerator fund to explore technology solutions to support with unanswered telephones and the challenge for families when trying to contact our teams/wards. As part of the funding,

the Health Board will receive support from SBRI who will set up a Project Board and help facilitate the process.

8.14 PALS Officers attended HMP Berwyn to deliver Patient and Carer Champion Training to help empower residents who are Peer Mentors. Peer Mentors provide a similar service to PALS. Further training has been scheduled for December to support the Peer Mentors in capturing patient stories and experiences of accessing BCUHB services in line with BCUHB Patient Story procedure.

8.15 The Patient and Carer Experience Lead is the chair of the Urology Patient and Carer Experience work stream. The purpose of the work stream is to ensure patient and carers have the opportunity to be involved in Urology service improvement.

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 total, Patient and Carer Experience Team captured 20 patient/carer stories. Examples include:

- A collection of experiences from patients accessing the specialist Primary Care Cardiac Care Clinic at Rysseldene Surgery, Colwyn Bay. The Cardiac Clinic helps reduce hospital admission by providing local support, care and treatment to patients, whilst helping bridge the gap between Primary and Secondary Care Cardiology Services.

  Learning – Overall excellent experience of the Cardiac Care service from the perspective of both patient and carer. Patients are benefiting from access to localised care reducing the need for patients to access acute hospital services. Staff are supportive in understanding the needs of the patients and what matters to them. This model can be replicated across the Health Board.

- A mum with two children with complex disabilities and medical needs shares her recent experience at Ysbyty Glan Clwyd accessing changing places facilities to support her son with toileting.

  Learning - To ensure this experience does not happen again BCUHB will ensure that the room is always open and available for use. This will be checked by undertaking continual reviews and spot-checks of changing room provisions. The changing room facility has now been incorporated into Quality Walkabouts of the hospital with senior staff members on a regular basis. The Board have asked staff to explore the issue of the hydrotherapy pool provision, and the provision of accessible facilities across the other sites.

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. PALS have been attending meetings with the Medical Examiner Officer to promote the role of the service.

10.1 PALS have been liaising with local Bereavement Officers across the Health Board to promote the role of PALS.

11 IMPROVING CARER EXPERIENCE

11.1 Supporting unpaid carers is a priority for the Patient and Carer Experience Department. To celebrate National Carers Rights Day on 24th November 2022, the Patient and Carer Experience Team co-ordinated a series of events across North Wales including information stalls in hospital areas hosted by NEWCIS and Carers Outreach and information videos promoting support available for un-paid carers for staff and the public.

11.2 Key carer experience activities 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
- Facilitated partnership working with NEWCIS and Ward 19 (Discharge Lounge) at Ysbyty Glan Clwyd to promote support for un-paid carers
- Supported partnership working between Ward 3 at Ysbyty Glan Clwyd and NEWCIS, this includes weekly ward visits from NEWCIS to capture new carer referrals.
- Supporting unpaid carer complex PALS enquiries.
- Patient and Carer Experience Lead representing BCUHB commissioning a young carers contract across Conwy, Flintshire and Wrexham County Council areas.

12 PATIENT & CARER CHAMPIONS

12.1 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 Patient and Carer Experience Team
- Participate in monthly updates.

12.2 Patient and Carer Champions work closely with the Patient and Carer Experience Team 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.

12.3 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 four guest speakers attending these meetings to deliver signposting and awareness training representing the following organisations:

- BCUHB Volunteer Service – awareness raising of Robin volunteers;
- Domestic Abuse Safety Unit – a not for profit organisation who supports victims of domestic abuse;
- St Kentigern Hospice – a local charity based in St Asaph providing care and support to patients with life limiting illnesses across North East Wales;
- BCUHB Rehabilitation Services.

12.4 The Patient and Carer Experience Team are helping facilitating mentoring across the staff Patient and Carer Champion network. A Patient & Carer Champion based in Wrexham Maelor Hospital is being mentored for support by a member of staff who is the Patient and Carer Champion of the year.

13 ACCESSIBLE HEALTH CARE

13.1 A recent accessible health care audit led by the Patient and Carer Experience Team in November 2022 identified the requirement for further sensory loss awareness training. Staff were not fully aware of the Sensory Loss Toolkit and resources available on SharePoint to support patients with sensory loss. To ensure all staff are aware of sensory loss the Patient and Carer Experience Team are working towards getting the Sensory Loss training mandatory on ESR.

13.2 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.

13.3 In September 2022, 18 staff in frontline staff attended Deaf Awareness Training organised by the Patient and Carer Experience Team. The course identified the barriers that deaf and hard of hearing people face and how best to communicate with deaf and hard of hearing people. Staff attending the course learnt the British Sign Language fingerspelling alphabet.

13.4 The British Sign Language Act 2022 recognises British Sign Language as a language of Wales and to enable access to BSL in everyday life. The Patient and Carer Experience Team will be revisiting the pledges BCUHB made at the All Wales 'It Makes Sense Event' in 2019 around the following the British Deaf Association charter themes:

- Consult formally and informally with the local Deaf community on a regular basis
- Ensure access for Deaf people to information and services
- Support Deaf children and families
- Ensure staff working with Deaf people can communicate effectively using British Sign Language

- Promote learning and high-quality teaching of British Sign Language.

14 WELSH INTERPRETATION TRANSLATION SERVICE (WITS)

14.1 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.

14.2 Digital equipment such as 'Translator on Wheels' are now placed in Emergency Departments, Outpatients and Women's Services. Across the Health Board, we make almost 500 bookings for interpretation and translation services per month from the Welsh Interpretation and Translation Service (WITS) costing on average £45,000 per month.

14.3 BCUHB have made changes to ensure Interpretation Services are easier to access, more cost effective, and a better experience for everyone. From December 2022, a new Language Line app is accessible from the desktop of BCU devices and through BetsiNet to organise interpretation services for patients. Organising interpretation through a video call via the app, or interpretation over the phone, is now the first choice when needing to arrange interpretation services. This ensures that we are able to provide translation services 24 hours a day, seven days a week, with minimal delays to patient communication.

14.4 British Sign Language interpretation will be accessed remotely unless the patient requests it to be face to face. The Health Board has historically often overspent on interpretation services. For 2023, the budget is predicted to be overspent by £87,000 without a change in how we organise these services BCUHB is currently spending £27,000 per month on travel alone. As well as being financially unsustainable, this dependence on travel fails to meet the Health Board's commitment to reduce our impact on the environment. Switching to focus on digitally provided interpretation gives us a reliable, financially and environmentally viable service we can access 24 hours a day, 7 days a week.

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 dissatisfaction with and difficulties accessing clinical treatment and/or assessments, access to appointments and communication issues.

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 Significant patient experience improvement activity is underway as detailed in the report.

15.6 The QSE Committee is asked to note the report.

Teitl adroddiad: ***Report title:***	Regulatory Assurance Report			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Tuesday, 01 November 2022			
Crynodeb Gweithredol: ***Executive Summary:***	This report provides the Committee with an updated position in relation to Healthcare Inspectorate Wales and Care Inspectorate Wales activity for the period August to September 2022.			
Argymhellion: ***Recommendations:***	The Committee is asked to note this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Erika Dennis, Quality Lead Manager			
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:***				
Steps to achieve acceptable assurance have commenced and are noted in the 'HIW Position August – September' of this report.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales, whilst Care Inspectorate Wales (CIW) are the independent inspectorate and regulator of social care in Wales.			
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?***	N/A			
Yn unol â WP68, a oedd SEIA yn angenrheidiol ac a gafodd ei gynnal?	N/A			

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)***	BAF21-10 - Listening and Learning
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
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) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- HIW Letter	

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

Regulatory Assurance Report to the QSE Committee October-November 2022

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

Regulatory Assurance Report to the QSE Committee October-November 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.

As the independent regulator of social care and childcare in Wales, Care Inspectorate Wales (CIW) register, inspect and take action to improve the quality and safety of services for the well-being of the people of Wales. They work in partnership with other regulators such as Healthcare Inspectorate Wales, Wales Audit Office and the Older People's Commissioner.

CIW regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services.

BACKGROUND

Internal Process

The Quality Directorate manage the internal HIW / CIW / quality regulatory process and activity for the Health Board on behalf of the Chief Executive and Executive Director of Nursing and Midwifery.

The team are currently reviewing and updating the Health Board's HIW Protocol. Process mapping exercises have taken place with key colleagues across the Health Board. The draft protocol was shared on the Health Board's policies consultation page in August 2022 which determined further engagement with staff is required.

The Quality Directorate are also engaging with HIW to ensure the protocol reflects their processes and timescales, and to consider any improvements we need to make to the management of regulatory activity and subsequent learning and improvement approaches.

Once finalised, the protocol will be submitted for further discussion and ratification in line with our process for policies and written control documents.

The protocol will be reviewed annually to account for any improvements and regulatory changes.

Improving 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 'trialling' the systems inspection module to capture and track HIW activity and improvement. 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, along with networking with other trusts across Wales.

This includes the embedding of the six domains of quality and 5 enablers in line with the Quality Act / Duty of Quality which comes into effect from 01 April 2023. These standards are known as the 'Quality Standards for Wales' and will replace the current Health and Care Standards for Wales 2015. This should be complete by the end of February 2023.

The system also has a 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.

Moving forward, the system should support our organisations whole system approach to quality.

Regulatory Assurance Group

The formation of a Regulatory Assurance Group chaired by the Executive Director of Nursing and Midwifery is underway and will take effect from 31 January 2023. The purpose of the group will be to monitor progress against regulatory action and improvement plans. Any issues of significance will be escalated to the committee via this report.

HIW ACTIVITY – OCTOBER TO NOVEMBER 2022

Services Requiring Significant Improvement (SRSI)

Inspection of Glan Clwyd Emergency Department

On 9 May 2022, Healthcare Inspectorate Wales (HIW) identified the Emergency Department, Ysbyty Glan Clwyd as a Service Requiring Significant Improvement (SRSI). At the time, the issues of concern were:

- Immediate Assurance and Improvement plan recommendations were not been actioned to an acceptable standard and within agreed timescales
- Similar issues have been raised during previous assurance activity and insufficient improvements mad
- A matter requiring urgent action was indicated through intelligence received or evidence gathered
- An accumulation of evidence, originating in January 2022, leading to the completion of a Quality Check on 8 March 2022 and an unannounced onsite inspection that took place on 3-5 May 2022. Several patient safety concerns were identified during this period.

During the most recent inspection (3-5 May 2022) HIW identified areas where the health board's actions in response to the previous Quality Check had not led to improvement.

HIW is working with the Health Board to ensure improvements are made in a timely manner. The SRSI status will be updated and the Health Board de-escalated, once HIW is satisfied that necessary improvements have been achieved.

During August 2022, the Quality Directorate collaborated with the Glan Clwyd (YGC) Improvement Programme Team led by the Programme Director for Clinical Safety Improvement, and the senior management team, to review all four improvement plans for the site in order to have a clear position on progress, including any immediate action required to make the service safe.

Following the review, the YGC Improvement Programme Team embedded the HIW improvements into the wider YGC Improvement Plan within the 'Sprint' element of the plan. The plan contains an audit cycle and is supported by a clear improvement methodology.

The Quality Directorate captured all of the improvement plans on AMaT, allocating an accountable lead. Subsequently, the YGC Improvement Programme Team have progressed with updating the improvement actions on the system as they work with the service to make the changes required.

Since the QSE Committee in November, there has been a 53% reduction in actions overdue for March with 19 now overdue as opposed to 41. In addition, there has been an increase in the amount of actions complete with a 73% increase of completed actions from 8 'completed' to 30 now complete. Overall, 44% of actions remain overdue.

For May, there has been an increase of 7% for completed actions with 30 complete as opposed to 28. Overall, 78% of actions remain overdue.

As previously reported to the committee, it is important to note that, 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. As such, the actions taken since the May report, include consolidation of the initial actions referred to in the improvement plan submitted to HIW in March with priority given to the immediate make it safes. This was highlighted to the Quality Safety and Experience Committee (QSE) in September 2022.

With reference to the above approach, The Quality Directorate has continued to work together with the YGC Improvement Programme Team and senior nursing and medical leadership, to support the closure of actions, particularly for March. A recent task was undertaken to cross reference March improvements with that of May. As reflected in the figures reported for March much progress has been made and work will continue into December to address both improvement plans.

The YGC Improvement Programme Team have undertaken a review 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 'Fully Complete' for the purposes of the action plan. Evidence is then uploaded to the AMaT system and approved or rejected via the Regulatory Assurance Group.

Local Review of the Health Board's Vascular Service

In February 2022 HIW designated our Vascular Services 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 patients using the vascular service.

As a consequence of the RCOS report and the SRSI designation, it is HIW's intention to undertake a local review to examine progress made by the Health Board in relation to the RCOS recommendations, and whether measures taken in addressing the RCOS recommendations are sustainable and ensure that patients receive safe care of good quality. The outcome of this review will enable HIW to consider whether the vascular service can be de-escalated as a SRSI

The fieldwork will consist of a number of different activities for which the Health Board's Medical Executive Director, has nominated a key contact for the review.

Following completion of a self-assessment to determine the services progress against the RCOS report and its recommendations in November, HIW have confirmed that they will be conducting their fieldwork across all three sites on 13th 14th and 15th December 2022.

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) at Appendix A.

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.

In order that HIW can assess the impact of patient flow challenges on the quality and safety of care for patients, they decided to focus their review on patients travelling through the stoke pathway. This includes the point of requesting an ambulance, through to a patients discharge from hospital or transfer of care to other services.

HIW have linked the review to their previous thematic review of Patient Discharge from Hospital to General Practice. The review made 13 recommendations for Health Board's to act upon. HIW requested a response which was provided earlier this year in February 2022, which would inform their Patient Flow review, and may also be published as a national summary.

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 status of both reviews are outlined below;

1. National Review – Patient Flow (Stroke Pathway) 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. Evidence will only be accepted where it demonstrates compliance.

2. National Review – Patient Flow (Stroke Pathway) Inspection of Glan Clwyd Hospital

On 15 November 2022, HIW wrote to the Health Board to provide an update following the onsite reviews which were conducted across Wales between March and September 2022 (for the Health Board this was July as noted above).

HIW have shared some of the broad findings in advance of completion of the full report which is scheduled for publication in spring 2023. These initial broad findings can be found in Appendix A.

At this point in time there is no action required by the Health Board other than to review the findings to provide an insight into what the recommendations may be.

Inspection of Wrexham Maelor Emergency Department

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.

From speaking with the Health Board's HIW Relationship Managers, the improvement plan is delayed due to issues with availability of Peer Reviewers. No date has been provided for receipt of the plan, however the Quality Directorate remain in contact with HIW Relationship Managers in relation to this and will ensure senior management are updated once any further information received.

Remote Quality Check of Rossett Dental Care (NHS Contract)

On 24 October 2022, HIW conducted a planned remote quality check of Rossett Dental Care in Wrexham (and independent practice).

HIW found areas of concern which could pose an immediate risk to patient safety. These issues included on the main, compliance with the Private Dentistry (Wales) Regulations (2017). Subsequently the practice completed and submitted an immediate improvement plan to HIW which was rejected as not providing sufficient assurance.

HIW accepted the re-submission of the Immediate Improvement Plan on 21 November 2022.

The Deputy Director Of Integrated Clinical Delivery - Primary Care (Interim) and the Acting Assistant Director for the North Wales Dental Service continue to provide oversight and support in relation to the action required in line with the contractual arrangements in place.

Unannounced inspection of Bryn Hesketh, Mental Health and Learning Disabilities

HIW conducted an unannounced onsite inspection of Bryn Hesketh. No immediate patient safety issues were identified during the inspection.

The Health Board received the improvement plan on 6 December 2022 which is being progressed by the service with oversight from the Interim Director of Mental Health and Learning Disabilities.

Unannounced inspection of Heddfan Unit, Mental Health and Learning Disabilities

HIW conducted an unannounced onsite inspection of Heddfan Psychiatric Unit between 7 and 9 November 2022.

Following the inspection, HIW issued the Health Board with an Immediate Assurance Plan as during the inspection HIW found issues which posed an immediate risk to patient safety in relation to the delivery of safe and effective care which were as follows;

- Compliance with Restrictive Physical Intervention (RPI) training
- Protection of patients and staff in relation to RPI – ensuring only staff who are compliant with RPI are involved with incidents of restraint
- Physical Restraint Policy requires review to provide clear guidance to staff

The service completed the Immediate Assurance Plan which was submitted to HIW on 18 November 2022. HIW confirmed that the completed plan provided sufficient assurance on 22 November 2022. The Health Board now awaits the main improvement plan which is expected during December 2022.

Unannounced inspection of the Emergency Department at Glan Clwyd

Further to the inspections undertaken in March and May 2022, HIW conducted an unannounced inspection of the Emergency Department at Glan Clwyd Hospital between 29 and 30 November 2022 with the intention to follow up on the areas for improvement highlighted during the previous inspection in May 2022.

HIW have issued the Health Board with an Immediate Assurance Plan as they were not assured that all risks to health and safety within the Emergency Department (ED) are managed appropriately. As such, they have highlighted some serious issues, which require immediate action by the health board.

The Executive Director of Nursing and Midwifery and the Acting Director of Quality have agreed and co-ordinated an approach for completion of the improvement plan which is due to be submitted to HIW on 8 December 2022. The committee are asked to note that prior to submission, the plan will receive Executive and HIW approval. Progress will be monitored via the AMaT system for quality assurance purposes and progress reported to the Executive Team, Board and HIW.

HIW Concerns and Enquiries

Between October and November 2022, the Health Board received a total of;

- 2 General Enquiries

- 9 Requests for assurances (includes concerns). These relate to; ENT Services, Cancer Services, Hydref, Heddfan, Emergency Department at Glan Clwyd, Llewelyn Ward at Llandudno Hospital.
- 2 Death in custody cases
- 3 Ionising Radiation (Medical Exposure) (IRMER) notifications

Further detail can be provided by the Quality Directorate upon request.

CARE INSPECTORATE WALES (CIW)

As the independent regulator of social care and childcare in Wales, CIW register, inspect and take action to improve the quality and safety of services for the well-being of the people of Wales. They work in partnership with other regulators such as Healthcare Inspectorate Wales, Wales Audit Office and the Older People's Commissioner.

CIW regulate adult services such as care homes for adults, domiciliary support services, adult placement services and residential family centre services.

The Health Board has become aware that there are domiciliary servicers we provide which are not registered. Whilst the Health Board is registered a provider for multiple services, registration currently only includes 'Enhanced Community Residential Services', and now needs to include 'Home First Services (Tuag Adref)', which is unregistered.

The Quality Directorate are liaising with CIW and key staff within the Health Board to ensure that the matter of registration is addressed without delay, and will assist CIW with exercising their regulatory requirements.

Gill Harris
Chief Executive
Betsi Cadwaladr University Health Board
Gill.Harris@wales.nhs.uk

Direct Line: 0300 062 8163
E-mail: HIW.reviews@gov.wales

Sent Via secure email

15 November 2022

Dear Gill,

National Review of Patient Flow (Stroke Services)

As you are aware, HIW is undertaking a national review of patient flow, which is focusing on the patient's journey through the stroke pathway. The review team conducted onsite visits to all health boards across Wales between March and September 2022 as part of the review. We wanted to provide you with an update on the progress of this review and share some broad findings in advance of completion of the full report, that will likely be published in Spring 2023.

We have been reviewing how patients flow through the healthcare system, particularly in line with the time critical nature for assessment and treatment for people suffering with a stroke, and their ongoing rehabilitation.

Throughout our onsite fieldwork within health boards, we considered the patient journey from the point of arrival at the Emergency Department (ED), either via an ambulance or by self-presenting, through to the point of discharge from hospital or transfer of care to other services.

During our fieldwork, we undertook a varied approach to gathering evidence which included:

- Reviewing numerous patient records and key documents within each health board, which focussed both on a retrospective review of records from 2020 onwards, and the records of patients in hospital at the time of our fieldwork

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- We held interviews with health board staff which included those who work within the ED, stroke services, patient flow teams and discharge teams, and those from the corporate team

- We interviewed staff onsite during our visits across Wales, and remotely via Microsoft Teams

- We observed numerous meetings, such as:
    - Multidisciplinary (MDT) Team meetings for stroke patients
    - Numerous hospital patient flow or bed management meetings
    - Health board escalation meetings.

As part of our review, we have also conducted a national public survey to obtain and understand the experiences of patients and/ or their families who have had a stroke, and a national staff survey to hear from those working within healthcare services across Wales, Social Care and Local Authorities. These surveys have now closed, and we are in the process of analysing the data collated.

It is positive to share with you that during our onsite fieldwork on 25, 26 and 27 July 2022, within Ysbyty Glan Clwyd, we did not identify any areas of immediate concern for patient safety, and we therefore did not need to write to you in line with our immediate assurance process.

As a result of the large scale of work undertaken, we have gleaned a vast amount of evidence across Wales through the health board self-assessment documents, our site visits, staff interviews, and the responses to our surveys. We are currently completing our work within the Welsh Ambulance Services NHS Trust and Public Health Wales, alongside the analysis of our fieldwork evidence to date.

The next stage of the review will be to draft a single national report, which will highlight the national themes and trends identified during our work, including areas of notable practice. We will also highlight the areas identified across Wales that require improvement and will make national recommendations. The report is due to be published in the spring of 2023, however prior to the publication date, you will be provided with the opportunity to comment on the report's factual accuracy as appropriate.

In the interim, we felt it would be helpful to share with you with a summary of the initial key general findings to date:

Patient assessment, treatment, and flow through EDs

- When considering patients arriving at ED with a suspected stroke, we found an effective alert process in place to alert clinical teams of an impending patient arrival with a suspected stroke

- Staff throughout Wales told us that due to an increase in ambulance delays, there has been a significant increase in the number of people self-presenting at EDs with a suspected stroke. In addition, some may present at ED feeling acutely unwell, but without obvious signs of stroke, when they may otherwise have been

immediately assessed as FAST positive for stroke (Face, Arm, Speech, Time assessment), if transported to hospital by an ambulance crew. This at times can prove challenging, since the departments are not pre-alerted to the arrival of these patients, but additionally, the check-in process at reception with the administration team can make the immediate assessment for stroke more complex when obvious stroke signs are not always visible. This may present a risk in the timely identification for some stroke patients

- We saw ambulances queuing outside EDs throughout Wales waiting to handover and offload patients. However, patients who were suspected of having a stroke (and others with life threatening conditions), were prioritised and were being transferred into the ED promptly and were assessed, investigations were undertaken, and treatment was commenced in a timely manner

- Overall, we found that EDs prioritise stroke patients appropriately, and staff mobilise other lower acuity patients (as appropriate) throughout the department to accommodate those confirmed as a stroke, to ensure timely assessment and provide ongoing treatment promptly as required

- There were inconsistencies across Wales with the rapid stroke assessment tools in place within EDs. In addition, when retrospectively reviewing patient records, we did not always find documented evidence that an assessment had always been completed by staff

- We established that stroke Clinical Nurse Specialists (CNS) were invaluable to instigating timely diagnostic treatments of patients in line with national guidance, and in providing expert treatment and care. However, there were inconsistencies across Wales in the provision of this services, in particular during out of hours

- Stroke assessments and interventions were being undertaken by clinicians with appropriate expertise in neurological disability, and nursing and medical staff have the appropriate knowledge, skills, and experience to recognise and manage stroke patients

- We found clear stroke pathways in place across Wales for those diagnosed with either a thrombolytic or haemorrhagic stroke, which focus on timely assessment, investigation, and ongoing treatment. In addition, there were pathways in place for patients who received thrombolysis, and for those referred to other hospitals for thrombectomy treatment

- The provision of thrombectomy treatment varies across Wales, with Cardiff and Vale University Health Board being the only health board that provides this service, and mainly to people who live within the locality. All other health boards in Wales currently rely on referring patients for thrombectomy to either North Bristol NHS Trust or to the Walton Centre NHS Foundation Trust in Liverpool. Given the geographical challenges and the impact of ambulance delays, this can negatively impact on the opportunities for patients be transferred across borders to receive treatment in a timely manner

- It is positive to note that across Wales a high number of registered nurses in ED can deliver thrombolysis where required, therefore the ED was not reliant on the stroke team or medical team to administer this medication for timely intervention.

Patient flow from the ED to the acute stroke ward

- Across Wales, we found it was not always possible to transfer patients to the acute stroke ward for ongoing care in a timely manner due to bed availability. This in turn maximised their stay within the ED and contributed to the delays with ambulance patient handovers. Alternatively, patients were being transferred to other 'non-stroke' medical wards until a bed became available in the acute stroke ward, thus preventing patients receiving are in the right place at the right time by the right staff

- We found some patients were outlaid on 'other' wards, which was reflected within patient flow/ bed management meetings and by ward teams. Whist policies are in place to ringfence acute stroke beds, this often not achieved due to the high escalation status of the acute hospital sites, and lack of bed availability

- Throughout Wales, we found appropriate senior management teams in place who were responsible for managing patient flow. The patient flow meetings highlighted the pressures across different specialties or service groups, such as medicine and surgery. There were some good processes in place to discuss the management of beds and identify the patient flow bottlenecks and challenges with patient discharge. Overall, flow meetings were held frequently and were well attended by the relevant key staff

- The number of patient flow meetings held in all health boards would increase at times of high escalation, when there were extreme pressures on the system. We found that hospital escalation levels were high at most patient flow meetings we attended across Wales. We noted discussions were also held in the flow meetings about longest queuing ambulances, and actions and plans were discussed in how to off-load certain patients into EDs

- Overall, patient flow teams appeared to manage meetings well. We heard discussions about each ward systematically and the position (capacity and staffing) of each ward and speciality. Concerns were highlighted and discussed appropriately within meetings, with effective communication regarding admission and discharge needs for patients

- In general, the patient flow teams had a good understanding of which patients required transfer or repatriation to other hospitals or community settings. We found an appropriate oversight of specialty outliers in other service groups, such as medical patients cared for in surgical beds and vice versa, however, this was common practice across Wales, and it was clearly not always possible to move patients to the most appropriate ward/ specialty for their care and treatment due to bed availability.

The acute stroke wards

- We saw evidence during all our site visits of wards proactively attempting to receive stroke patients from ED at the earliest opportunity. Each health board aimed for admission to the acute stroke ward within four hours of admission to ED. However, this was not always possibly due to bed occupancy and bed availability, although, we found that ward teams and stroke CNSs were in regular communication with EDs in preparation to receive patients

- Across Wales, ward rounds are undertaken daily, Monday to Friday. However, the rounds do not routinely take place during weekends or bank holidays, which has the potential to impact on patient care and rehabilitation. We observed board rounds and MDT meetings during our site visits which overall, were found to be well structured and identified requirements, actions and goals to move patients to the next point along the pathway

- We saw that patients are considered and discussed on an individualised basis during the board rounds and MDT meetings. We saw early planning for discharge and for the transfer to other departments for treatment and therapies. Planning for ongoing care to facilitate rehabilitation and discharge from hospital. However, there were numerous prolonged delays in the allocation of social workers, and social care packages as well as delays in obtaining nursing or residential home placements

- We found inconsistencies in the ability to provide timely and/or all the required therapy services and rehabilitation of patients across Wales. This was for several reasons, such as staffing availability/vacancies, different specialty outliers affecting space on wards across hospitals, and the general ward or department environment relating to facilities and space for the provision of timely rehabilitation services

- We found inconsistencies in the provision of psychological support to stroke survivors across Wales with not all health boards providing support in this area.

Preparing for discharge from hospital

We are supported by Care Inspectorate Wales (CIW), to further explore the discharge element of patient flow, in particular regarding the provision of social care. This area will be further highlighted within our national report upon completion of the review.

- During our interviews across Wales, we were told that patients entering hospitals with a stroke were much frailer and even more complex than pre-pandemic. Stroke patients had a range of other physical, cognitive, and other medical needs. COVID-19 had meant that many patients did not seek ongoing medical (or other) support, during the lockdown periods and therefore their conditions had deteriorated

- Our onsite fieldwork identified additional barriers to timely patient flow. This included the ongoing effects of COVID-19 which continued to cause delays with hospital-to-hospital transfers, and discharge to community beds, nursing/ residential homes, or usual place of home

- We found all therapy services have an active role in the care and discharge planning for each patient, and overall, we found good collaborative working between them and medical teams

- Across Wales, health boards have designated staff responsible for the discharge of patients. Patients who are clinically optimised can be referred to social services for a social worker allocation. Whilst there were variations across health boards in the timeliness of the allocation of a social worker to each patient, some reported waits of up to three weeks or more. This alone can delay a patients discharge. In addition, if a patient requires a 'Best Interest Meeting' once clinically optimised, there are delays and difficulties in arranging the meetings to ensure all relevant stakeholders are in attendance

- When patients were deemed ready for discharge, there were frequent long delays in obtaining packages of care for patients across Wales as a whole, with minimal knowledge in some cases of when these packages could commence. Where a patient was awaiting a placement in a nursing or residential home, we found dates were often set for transfer out, or plans were in place to cover the interim period elsewhere in reablement beds, before the placement was available, however this was not consistent across Wales due to bed availability

- Engagement with the Early Supported Discharge (ESD) Team highlighted the benefits in the service provided to facilitate patients returning home earlier and to receive rehabilitation at home. However, we identified that there are inconsistencies with the provision of ESD services across Wales. Where the service was available, staff reported improvement in patient flow due to savings on patient bed days

- We explored issues with complex patient discharges and found that long waiting lists along with multiple assessments, each contribute to long discharge delays, adding further pressure in the healthcare system and patient flow. We also found delays with social worker allocation, the set-up of Best Interest meetings, availability and commencement of social care packages, minimal availability of residential or nursing home beds, and minimal availability of reablement beds, all of which impact on patient flow through the healthcare system

- We found one of the main delays hindering patient flow and early daytime discharge (such as early morning), relate to the availability of social care packages. These often do not start until the afternoon or evening on the day of discharge for many patients across Wales, which prevents early discharge, thus adding to the burden of delayed ambulance handover, busy EDs, and bed capacity across both acute and rehabilitation wards.

As highlighted, these are our initial broad findings from our work to date, and the review is continuing to analyse the evidence captured. The final report will elaborate on these areas accordingly and provide more detail. The report will also identify good practice and identify areas for improvement, making recommendations that will aim to address the challenges in relation to patient flow.

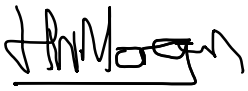
It will be our expectation that the recommendations are considered by each health board individually, and in turn, each will provide HIW with an action plan to consider and address any areas for improvement.

As highlighted earlier, prior to publication, health boards will be provided with an embargoed copy of the report to review and comment on its factual accuracy. Further details regarding this will be provided in due course.

We hope that you find these interim findings helpful and provide you with a sense of the key issues and themes that the final report and its recommendations will focus on. At this stage we are not requesting a written response from you in relation to this letter. However, we expect you to share the content with key people for information until our national report is published.

If you have any queries or concerns about the content of this letter, please e-mail HIW.reviews@gov.wales, or telephone 0300 062 8163. Alternatively, you may contact me via email at helen.morgan011@gov.wales.

Yours sincerely



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Teitl adroddiad: ***Report title:***	Quality Achievements			
Adrodd i: ***Report to:***	QSE Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023			
Crynodeb Gweithredol: ***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.			
Argymhellion: ***Recommendations:***	The committee is asked to receive this report.			
Arweinydd Gweithredol: ***Executive Lead:***	Angela Wood, Executive Director of Nursing and Midwifery			
Awdur yr Adroddiad: ***Report Author:***	Matthew Joyes, Deputy Director of Quality Amanda Blaynee-Roberts, Quality Business Support Manager			
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:***
N/A

Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Quality
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	N/A
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?***	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)	BAF21-10 - Listening and Learning

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***	N/A
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	N/A
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) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	BAF21-10 - Listening and Learning
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	N/A
Camau Nesaf: Gweithredu argymhellion ***Next Steps: Implementation of recommendations*** N/A	
Rhestr o Atodiadau: ***List of Appendices:*** Appendix A- Quality Achievements	

Betsi Cadwaladr University Health Board
Quality Achievements

Men's Health Support

ICT Technicians came together at the beginning of November to grow a tremendous set of moustaches in support of men's health issues which many men ignore or do not seek support for at an early stage.

November is often the time of year where men's physical and mental health comes into the spotlight. Members of the BCU ICT support team are doing their bit to raise awareness of issues such as men's mental health and suicide prevention, prostate cancer, and testicular cancer.

Aaron Jones, David Beard, Dylan Satelle, Ioannis Tagaras, James Edge, Paul Graver and Sion Roberts are keeping their top lips warm as they grow their moustaches during November.

2023 Apprenticeship Awards

Daf Edwards who works within our IT department has been nominated in the Apprentice of the Year Management category at this year's Grwp Llandrillo Menai Apprenticeship Awards.

Daf is an extraordinary man. Following a huge brain haemorrhage in November 2020, doctors gave him no hope of recovery and asked his wife to consider donating his organs.

However, he refused to give up and he awoke from a coma a few weeks later. Due to the brain damage, Daf had to learn how to speak, eat and walk again and it took him 15 years to recover enough to find a job.

Wanting to repay the health board that saved his life, he secured a backroom role in the Covid Testing Centre at Ysbyty Alltwen, Tremadog at the start of the pandemic.

Having gained qualifications, including the Diploma in Management Level 3, Daf now has a full-time job in the IT department with us in West.

The winner of the award will be decided by the public – voting is open until 14 December

New Language Line App available as Health Board goes digital-first for Interpretation

The Insight Language Line app has been installed on desktop devices pan BCUHB in order to provide translation services 24 hours a day, seven days a week, with minimal delays to patient communication. The Insight app has also been installed on Wales Nursing Clinical Records devices in the East and Central areas and will be uploaded to West devices in line with the WNCR roll out plan during early 2023.

Patients who communicate through British Sigh Language (BSL) can access interpreters through the app but can also request a face-to-face booking.

Bevan Exemplar Programme – Cohort 8: Driving Change in Challenging Times

Following on from previous years' success, the Bevan Commission's Exemplar Programme Cohort 8 Call for Application is now open and receiving applications. Successful applicants to Cohort 8 of the Bevan Commission's Exemplar Programme will be expected to start the programme on the 7th March 2023.

This year, the Bevan Commission encourages project applications, which align with the following themes:

- Preventing Illness, Early Intervention and Supporting Care in the Community
- New Models of Integrated Health and Social Care
- Reducing Waste across Health and Care
- Supporting the Recovery of Elective Care
- Improving Care for Patients with Cancer
- Reducing Inequalities and Transforming Mental Health Services
- Other areas consistent with your organisation's priority areas

Project proposals may include, new products, processes or services, new ways of working, new service delivery models or interventions, novel skills development initiatives or other innovative approaches to delivering change.

Celebration of Nursing Support Workers' Day – 23rd November 2022

More than 5,000 people work as healthcare support workers, assistant practitioners and in other nursing support roles across Betsi Cadwaladr University Health Board. They play an enormous part in the services we deliver, and in the support, we provide to our patients and their families.

On the 23rd November 2022, Executive Director of Nursing and Midwifery Angela Wood met with a group of nursing support staff at Ysbyty Glan Clwyd to hear more about their priorities and aspirations – and recorded a special video message to thank staff in these roles for their hard work.

Colleagues from our Nursing Education and Development team were on hand at Ysbyty Gwynedd, Ysbyty Glan Clwyd and Wrexham Maelor Hospital to help showcase the training opportunities open to all nursing support workers – and to share some memorabilia and other talking points.

Dietitian Wins National Award for her Passion and Dedication

A prison dietitian has been named Clinical Nutrition (CN) Professional of the Year at the national CN Awards. Fran Allsop, a dietitian at HMP Berwyn in Wrexham, one of the largest prisons in the UK, helped set up a new dedicated dietetics service in the prison. Here she assesses patients via telephone or in face-to-face clinics for a wide range of conditions including, weight management, type 2 diabetes mellitus, coeliac disease, oncology, inflammatory bowel disease, oral nutritional support and irritable bowel syndrome.

Fran has also started a first of its kind weight management group for the men at the prison and manages the nutritional needs and risks of prisoners on food refusal. Fran said: "I'm delighted to have won this award; prison dietetics is an underrepresented area of practice in dietetics. I hope this award will raise the profile of the role within this niche environment and help lobby for the nutritional needs of prisoners nationwide.

Carers Rights Day - The rights of Unpaid Carers

Carers Rights Day took place on Thursday 24th November 2022. Carers Rights Day is a national campaign that brings organisations together to help unpaid carers know their rights and find out how to get the support they are entitled to. Each year Carers Rights Day has a theme, and this year's theme was 'Caring Costs' and focuses on the rights of unpaid carers.

Many people are taking on more caring responsibilities for their relatives and friends who need support. Each year, Carers Rights Day helps to:

- Ensure carers are aware of their rights
- Let carers know where to get help and support
- Raise awareness of the needs of carers

BCUHB have policies and support in place for staff who also have unpaid caring responsibilities.

Conference for new BCUHB team supporting CAMHS in Schools across North Wales

Following a successful pilot programme in both Wrexham and Denbighshire between 2018 and 2021, the North Wales CAMH (Child & Adolescent Mental Health) Schools In-Reach Service is now fully accessible to all schools across all counties throughout North Wales.

This service is specifically to support all schools across the region in addition to existing CAMHS provision within the area. The service will be presenting at a Head Teacher Conference in Llandudno on 23rd November to share the objectives and successes of the scheme so far.

The aim of the Schools In-Reach team is to:

- Supply support to educational staff for their emotional health and wellbeing.
- Supply training to education staff covering several areas i.e., Youth Mental Health First Aid, Adult Mental Health First Aid, stress in the workplace and five ways to wellbeing.
- Provide consultation to support indirectly learners who have been identified by school staff as needing aid with their mental health and emotional wellbeing.
- Provide contact and support to your school in promoting mental health and wellbeing in line with new curriculum for Wales and the implementation of the Whole School Approach Framework.

The Schools In-Reach Team consists of qualified and experienced mental health professionals who are available in addition to the existing CAMHS (Child and Adolescent Mental Health Service) specialist service provision.

Teitl adroddiad: ***Report title:***	2022/23 Quarter 2 (Q2) Health and Safety Report			
Adrodd i: ***Report to:***	Quality Safety & Experience			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023			
Crynodeb Gweithredol: ***Executive Summary:***	The Quarter 2 report provides an update on the work undertaken by the Corporate Health and Safety (H&S) Team during the period between 1 July 2022 and 30 September 2022. The report requires the Board to implement the three year OHS Security Strategy and approve the current Security Business Case and implement Policies for Security and V&A and progress the security redesign project. The Quarter 3 report will be submitted to the next QSE meeting 07 March 2023.			
Argymhellion: ***Recommendations:***	The Board is asked to note the recommendations within the report which include:- ▪ Ensure adequate staffing is available to provide an appropriate Health and Safety, Security, Fit Testing and Manual Handling function to BCUHB. ▪ Ensure appropriate trainers are available to ensure the Manual Handling risk is reduced from the current level. ▪ Update the Manual Handling Policy and training outcomes reviewed. ▪ Review ligature risk assessments in all service areas ▪ Establish a COSHH management group and undertake reviews of COSHH arrangements			
Arweinydd Gweithredol: ***Executive Lead:***	Sue Green Executive Director of Workforce and Organisational Development.			
Awdur yr Adroddiad: ***Report Author:***	Pete Bohan, Associate Director of Occupational Health, Safety and Security Sue Morgan, Head of Health Safety and Security			
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):***	Improve the safety and quality of all services
Regulatory and legal implications:	Failure to comply with Health and Safety legislation can lead to the increased risk of accidents and incidents occurring and the risk of enforcement action, prosecution, fines and compensation claims.
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 all policies and procedures have EQiA as part of the evaluation process.
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?***	No Health and Safety legislation does not directly relate to the socio economic duty.
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 report should be cross referenced with the Board Assurance Frmework (BAF) Security Services No 21-12 and Health and Safety BAF Reference No 21-13.
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There is significant financial risk as it is anticipated the possible prosecution of BCUHB will result in fines of between £1.5M and £6M
Workforce implications as a result of implementing the recommendations	Staff not trained in specific Health and Safety issues may result in ill health and injury to staff and patients.
Feedback, response, and follow up summary following consultation	Paper not been reviewed at other groups.
Links to BAF risks: *(or links to the Corporate Risk Register)*	The report should be cross referenced with the Board Assurance Frmework (BAF) Security Services No 21-12 and Health and Safety BAF Reference No 21-13.
Rheswm dros gyflwyno adroddiad i fwrdd cyfrinachol (lle bo'n berthnasol) ***Reason for submission of report to confidential board (where relevant)***	Not applicable

Next Steps:
Implementation of recommendations

- Recruitment procedures are being undertaken for the Health and Safety, Security, Fit Testing and Manual Handling function to support BCUHB. This has been complex with delays in approving job descriptions, a lack of candidates applying and candidates withdrawing applications.
- The Manual Handling Policy is in the process of being updated
- A schedule of joint ligature risk assessments in MHLD areas is being completed and the visits have commenced
- A COSHH management group has been established and reviews of COSHH arrangements are being undertaken

List of Appendices:
Appendix one: Health and Safety Snapshot
Appendix two: Health and Safety Reviews completed Q2
Appendix three: Violence and Aggression incidents
Appendix four: Manual Handling Training data
Appendix five: Fit testing data

Quality Safety and Experience Group

2022/23 Quarter 2 (Q2) Health and Safety Report

1. Background

The gap analysis undertaken in September 2019 identified significant areas of concern in the management of OHS within BCUHB. The OHS Team developed a comprehensive action plan to identify and mitigate the risks identified. This action plan included key areas of risk such as, contractor management and control, work at height, vibration and noise, asbestos, legionella water safety, driver safety, security, violence and aggression (V&A), fire, electrical safety, manual handling and incident reporting procedures to ensure when things do go wrong we learn lessons. There has been progress made on a number of areas of concern, however there is further work required particularly on the issues of in-patient falls, manual handling, stress and Security and V&A and these remain priority areas over the next 12 months.

2. Body of report

1. Health and Safety Executive (HSE)

1.1 HSE Inspection, Patient Handling and Patient Falls risk assessments

A further HSE inspection of patient handling and patient falls risk assessments was undertaken on the Wrexham Maelor Hospital site on the 18th of May 2022. Although improvements were noted in the four areas visited, there was still work required to ensure both risk assessments are suitable and sufficient. The HSE inspector provided feedback via an email detailing concern over the effective progression of the model of training and support the team had detailed, this needed urgent progression and delivery with consistency across all hospitals, particularly where adult in-patient falls have been identified. Regular monitoring of patient falls and patient manual handling risk assessments by senior ward personnel is required to drive improvements and this level of ownership should be the target of the process. It was identified during the inspection that assessments seen

still failed to detail what equipment was required to prevent falls and there were inconsistencies between the patient falls and patient handling risk assessments.

In Q2 the focus was for the wards to make contact with the multi-disciplinary team supporting with the bedside learning programme through identified Falls Leads, to help staff complete accurate and effective patient handling and patient falls risk assessments. Progress on this will be reported in the Q3 report.

1.2 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 and a response has been submitted to both letters.

1.3 HSE Investigation, Facilities Staff Manual Handling Training

A complaint was made to the HSE advising that facilities staff in Llandudno hospital had not received Moving and Handling training. This has been checked and training has now been booked for those staff who had not received training or who were out of date with their refresher training. All staff have now attended training and a programme for training facilities staff across BCUHB is required.

2. Health and Safety Gap Analysis Action Plan

Work has continued to update the gap analysis action plan this quarter. Areas that sit with Estates including Water Safety, Electrical Safety, Asbestos Management, Gas Safety and the Management of Pressure Systems have been fully reviewed and action plans created that are monitored under specific Estates meetings. In addition a full review of the management of the risk of Hand Arm Vibration within the Estates Team was completed and the action plan will be updated as a standing item on the Pan BCUHB Estates H&S Meeting. An indepth review of Fire Safety was carried out and a report has been submitted to the Estates team.

3. Three Year Strategy

The action plan to ensure that tasks for year one of the three year strategy have been completed and work has commenced. Once this action plan has been completed it will remain under the scrutiny of the Strategic Occupational Health and Safety Group.

4. Corporate H&S reviews

Corporate Health and Safety reviews are required under the BCUHB Health and Safety Policy as part of the mandatory requirement to monitor H&S compliance. The KPI for the team, which includes both the Health and Safety Advisors and the Health and Safety (Fit Testing) Advisors, is 63 this quarter across East, Central, West and PC and a total of 66 reviews were carried out in Q2. Departments reviewed and compliance scores obtained can be found in Appendix Two.

5. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

A total of 11 RIDDOR reports were made to the HSE in Q2.

- 3 incidents relating to patients
- 8 incidents involving staff

6. Datix incidents (Personal Injury)

A total of 328 staff incidents were reported in Q2 under the datix category 'Accident / Injury'. These break down into 50 slip, trip, falls and collisions; 66 needle stick and sharps; 20 patient handling incidents; 28 object handling incidents; 2 burns/scalds; 20 contact with object or animal; 15 exposures to hazardous substances; 5 entrapment; 18 Road Traffic collisions and 30 striking against or by an object incidents; 74 exposure to COVID-19.

7. Health and Safety Training

Training via Microsoft Teams remained in place for Q2 including COSHH, risk assessment and RIDDOR along with a Manager's H&S Toolbox talk on a rolling four week programme. In Q2, 12 training courses took place with a total of 121 attendees. IOSH Leading Safely courses will commence in Q3 and are a mandatory training requirement for all staff band 8D (or equivalent) and above.

8. Security/V&A

8.1 Security

The security business case for permanent staffing is with the Executive Director. This is circa £1.5 million spend with the Security Advisory Team and the Security Guarding provision for one of the proposed options. There are further options of a clinical response team in the acute sites and a hybrid intervention clinical violence reduction model working in conjunction with traditional security elements.

The Executive Director has confirmed that capital allocated in the Integrated Medium-Term Plan, can be used to make the Regional Security Advisory and Security Contracts Manager positions permanent within BCUHB. The BCUHB Security Advisors are making positive interventions in conducting security assessments, directing security contractor duties, raising the security culture profile and providing professional advice and support to all corporate and clinical areas.

Areas of the three-year Health, Safety, and Security strategy have been aligned, and based on the outcome of the Security Business case, will dictate further developments of the new security structure within the organisation and further development of staff training in high-risk areas as well as lockdown polices and producers.
Positive in-roads have already been achieved within many areas of the strategy including, improvement to high-risk areas, Violence & Aggression Training interfacing with ESR systems.

SGC remain at present the current contracted security provider who provide 24/7 cover at the three acute sites, with confirmed funding until the end of January 2023. They also continue to provide other services of the bed watch function, Infection prevention guards and other ad-hoc requirements in relation to site vaccine security, storage and pop-up locations supporting the vaccine roll out programme. These resources are continuously being evaluated, with resources in some areas gradually downscaled.

8.2 Reported incidents of Violence/Aggression & Security

The new Datix system went live on 1 April 2022. This new system currently lacks some of the features of the old system. There are also different categories which has had a negative impact on data collection.

During Q2 2022 there were 1295 Security, V&A related incidents recorded on the Datix system effecting all persons (Staff, Patients & others) compared with 1220 incidents in Q2 2021. See

Appendix Three for further details. All Violence/Aggression and Security Datix incidents have been reviewed thanks to the additional staff resource of the Security/V&A advisor, with offers of support made in those incidents where harm has been identified.

8.3 Obligatory Responses to Violence in Healthcare

A Welsh Health Circular was issued that enhanced the Obligatory Responses to Violence in Healthcare status in April 2021 supported by Welsh Government. Regular meetings are held with the senior police officer who is the dedicated point of contact for the Obligatory Responses.

There are 30 open cases with the Violence and Aggression Case Manager with 47 being closed in Q1 and Q2. Not all cases progress within criminal justice system as some cases require on-going risk management planning in collaboration with the multi-disciplinary teams concerned. Often these cases can span across different financial quarters.

There are continued attempts by Violence and Aggression Case Management to highlight the need for engagement within those areas, which are volume generators of violent incidents where staff are victims of violence such as mental health. Links are developing with the deputy medical director of mental health in order to improve communication, understanding and knowledge for lead clinicians. Poor engagement in the past has led to several failed/discontinued police investigations. The appointment of Band 4 V&A trainers/advisors is expected to highlight the supportive ethos of the Obligatory Responses process to both staff victims and line mangers in 2022/2023, with initiatives such as a trial telephone contact process with staff caused harm and support offered to managers following Datix submission.

Whilst not part of the Obligatory Responses to Violence in Healthcare the V&A Case manager attends regular Safeguarding led Workplace Safety Group Meetings, these meetings are to advise on practical safety measures in the workplace for those staff victims & perpetrators of domestic abuse

8.4 Personal Safety Markers

Communicating a patient's past behaviour in relation to violent/threatening incidents is fundamental to reducing the risk of further violence. To this end, the aim of a personal safety marker is to assist in early alerting of individuals who pose a risk of violence towards BCUHB employees. The Personal Safety Marker (for Violence/Aggression) is yet to be adopted, largely due to infrastructure and compatibility issues surrounding the electronic patient note system. Work in this area has remained static over several years due to the compatibility issues experienced by the electronic note system. BCUHB Informatics department inform that there is national work stream exploring if such markers can be placed on the electronic notes system. There is no single electronic notes system that interfaces with all other systems.

8.5 Changes in Legislation

The Welsh Government have yet to sign a commencement order in respect of section 119 & 120 of the Criminal Justice and Immigration Act 2008, which makes causing a nuisance or disturbance on NHS property an offence and gives powers of removal using reasonable force to NHS employees. This may have training implications for BCUHB staff and potentially contracted security staff. Representations have been made to Welsh Government by various national security and V&A groups to sign a commencement order so that the law can be enacted and given equal status as it is in England.

The above statement remains- The All Wales Case Management Group has met in Q1 and Q 2 with the emphasis placed on the reestablishment of reporting and governance structures due to the disruption caused by the lack of meetings during the pandemic. Once governance structures are

developed then representations will continue. The issue of the commencement order remains a standing agenda item on the All Wales Covid Security group, which meet on a fortnightly basis.

The United Kingdom Protect Bill update is expected autumn 2022 this may have some implications in respect to “public spaces” risk management, emergency planning, infrastructure upgrades and location equipment such, as tannoy ,public address systems, emergency readiness packs (trauma for major incidents) and health and safety PPE equipment for staff.

The Phase-2 of the Fuller report; Relating to November 2021 following criminal convictions with regards to events that took place in a Mortuary, located in Tunbridge Wells in Kent are due to be released. With further recommendations for minimum security operating standards, required for Mortuary’s and Body-Stores in the United- Kingdom. This could also coincide with further recommendations from the Human Tissue Authority (HTA) and the final of HBN-16 for Mortuaries. These are now due to be released mid-Q3 after delays.

8.6 Policy/Procedure development/reviews

HS023 Closed Circuit Television (CCTV) and Body Worn Video (BWV) Policy has been approved and went live in March 2022. Efforts focus on ensuring all BCUHB sites comply with the policy. Hospital Management Teams (HMT) at three district Hospital sites were targeted to comply (including support) with the policy requirements. Response/progress has been poor however; BCUHB security advisors continue attempt to positively influence HMT’s to embrace the policy.

8.7 V&A Training

A total of 27 sessions were offered in Q1 with 244 staff trained by the team in Module C (Breakaway).

9. Manual Handling

9.1 Manual Handling Team

The Manual Handling Team currently has a Band 7 (interim) Manual Handling Manager (the successful applicant withdrew from post after 2 weeks), 1 Band 6 Manual Handling Trainer/Advisor and 3 Band 4 Manual Handling Trainers. 1 further Band 6 is awaiting clearances via TRAC and 2 Band 6 posts have gone back out to advert for West and Central Areas. We have recently interviewed for Band 4 Trainers and these are in the process of the interviewing stage. We hope to recruit to 4 posts.

9.2 Student Nurse Training

This is all booked in for Bangor and Glyndwr Universities with income generation being utilised for staff training and new equipment within the service.

9.3 External Manual Handling Trainers

We continue to use Acumen Care Education to support with Foundation and Refresher training. We have dates booked in until December and have requested their availability for January 2023, ensuring we keep within the budget allocated.

9.4 Equipment

Following discussion, we are currently putting an SBAR together to support the purchase of Mangar Elk lifting equipment in all the training rooms. There is a project group identifying other flat lifting equipment required. The plan would be then to offer training on these.

9.5 Manual Handling Champions

Our Champion refresher courses are now back up and running on all three sites within Betsi Cadwaladr University Health Board.

9.6 Training details including DNA Rates

DNA rates remain high and reports are sent to appropriate heads of departments to report this. Training figures can be found in Appendix Four

9.7 Interactive Screens

The interactive screens are now set up and working on each training site improving the delivery of training in the classroom.

10. Fit testing

10.1 Fit2Fit Accreditation

Our Fit Testing Advisor in the East has now gained Fit2Fit Accreditation. This means we can now train fit testing on each site and therefore increase sessions. We also attend regular online training sessions held by TSI to learn and keep our techniques up to date.

10.2 Fit Test Training

During Q2 the following staff have been trained to undertake fit testing:

	New Trainers	**Refresher Training (every 2 yrs)**
West	7	6
East	5	6
Central	4	3

10.3 Respirator Identification Card Trial

East Area now have a Fit Testing Coordinator in post and therefore have a card printing machine in place.
There are 2 audits per month held on each site in staff areas to check if badges are being worn and the feedback is positive regarding wearing them.

10.4 New Starters

We continue to work with WOD and receive a monthly report of all new starters who have commenced employment within the last month. We then contact these staff to prompt them to arrange a fit test.

10.5 Student Nurses /Bank Staff

We continue to work with the local Universities to ensure that students are captured for fit testing. The University sends out emails to the students requesting that they make contact with the Fit Testing Co-ordinators via the generic email 3 weeks before their placement date. Once tested they send copy of their certificate to the University who then uploads this data onto their drive so they can see how many have attended and who to chase if required. This is currently working well. The Bank

nursing team work in a very similar way but do not allocate shifts to the member of staff until they have had a successful fit test.

10.6 Fit Testing Escalation Protocol

The Escalation Protocol has not been actioned in Q2.

10.7 Fit Testing Activity

Across BCUHB in Q2 1399 fit tests were undertaken across BCUHB. Although the number has increased as expected, we experienced a high rate of DNA's from the new rotation of clinical staff. This has been escalated to the HMT. Details are in Appendix Five

10.8 ESR Competencies/Fit Test Data

Discussion is still ongoing whether all staff input their own results into ESR from their certificate provided following their test, then their manager approves this if appropriate. This would work in the staff members favour to ensure their compliance is up to date when applying for study leave or attending their PADR. All parties need to ensure that our data is accurate before making changes.

10.9 Falls

This team continues to lead on the falls project following the visit from the HSE. They have attended wards to audit patient paperwork and undertake training with staff.

10.10 Health and Safety Reviews

The Fit Testing team are now supporting with Health and Safety Reviews within all three areas, working closely with the Health and Safety Advisors to ensure that KPI's are met for the team.

10.11 COSHH Assessments

To support the three year strategy this team meet with other members of the COSHH Group Forum bi-monthly and will introduce a programme of COSHH assessments in high risk areas. These are additional to the Corporate H&S Review where a brief look at COSHH arrangements is also undertaken. The team have taken over the COSHH training from the advisors which is held once per month via Teams.

11. Recommendations

- Ensure adequate staffing is available to provide an appropriate Health and Safety, Security, Fit Testing and Manual Handling function to BCUHB
- Approve the current Security Business Case and implement Policies for Security and V&A and progress the security redesign project
- Ensure appropriate trainers are available to ensure Manual Handling risk is reduced from the current level
- Implement the 3 year OHS and Security Strategy
- Update the Manual Handling Policy and training outcomes reviewed
- Review ligature risk assessments in all service areas
- Establish a COSHH management group and undertake reviews of COSHH arrangements

3. Financial Implications

There are significant budgetary implications, which are currently not funded for Security guarding on sites. The business case for Security and V&A describes options for in house or externally sourced guarding on DGH sites. This has been shared with the relevant Executive Directors. The major financial implications include staffing for Security and Health and Safety, Training packages include the Institute of Occupational Health (IOSH) Director/Leading Safely and Managing Safely programmes and fit testing staffing. Estates related software includes MiCad for schematic drawings of the estate and SHE for managing contractors, Sypol for Control of Substances Hazardous to Health, water safety findings and asbestos management plan with the implementation of risk assessment findings for fire and compartmentation particularly in Ysbyty Gwynedd.

4. Risk Management

The significant risks have been escalated through the Board Assurance Framework and were previously agreed by QSE. These include Leadership of OHS and Security Management. The specific Estates related risks including Contractor Management and Control, Asbestos, Legionella and Fire Safety are now on Tier 1 risk register. Estates will directly manage these with OHS support. The H&S Department has provided over the past 18 months specific audits on all service areas described above along with electrical safety, gas, pressure systems and vibration management. Action plans have been provided and the Estates Department have established specific group meetings to monitor findings of audits undertaken and track action plans.

5. Equality and Diversity Implications

The impact of non-compliance with Health and safety legislation described will have a detrimental effect on staff health, safety and wellbeing at work this includes both physical and mental health.

Appendix One, Health and Safety Snapshot

Appendix Two, Health and Safety Reviews in Q2

Primary Care

13/07/2022	Benllech	Y	100%	
13/07/2022	Amlwch	Y	100%	
14/07/2022	Botwnnog	Y	70%	
28/07/2022	Yr Hen Orsaf Medical Centre Bethesda	Y	97.96%	
28/07/2022	Bethesda	Y	97.62%	
03/08/2022	Bala Medical Centre	Y	70.83%	
11/08/2022	Wxm Health Centre	Y	82.95%	
18/08/2022	Minfor Medical Practice	Y	81.25%	
18/08/2022	Barmouth	Y	96.34%	
18/08/2022	Dolgellau	Y	97.56%	
07/09/2022	Llanberis	Y	55.44%	
21/09/2022	Beech Ave., Rhos	Y	95.74%	
22/09/2022	Ty Doctor, Nefyn	Y	77.91%	

East

01.07.22	Gwanwyn Ward, Heddfan OPMH	Y	73.40%	
04.07.22	Gladstone - Deeside CH	Y	86.04%	
04.07.22	Preswylfa	Y	70.58%	
07.07.22	Gresford District Nurses	Y	44.40%	
14.07.22	Mental Health Liaison Team, Heddfan	Y	81.40%	
11.07.22	Wrexham Vaccination Centre	Y	84.60%	
21.07.22	Flintshire Vaccinations (Preswylfa)	Y	88.10%	
28.07.22	Treweryn Ward, Heddfan MHU	Y	78.60%	
11.08.22	Radiology Department	Y	83.69%	
26.08.22	Flintshire DNs (Mold)	Y	50%	
09.09.22	ED, WM	Y	67.40%	
15.09.22	Clywedog Ward, Heddfan MHU	Y	69.10%	
23.09.22	Dyfrydwy Ward, Heddfan MHU	Y	63.70%	
29.09.22	Radiology Department - Deeside	Y	73.90%	

Central

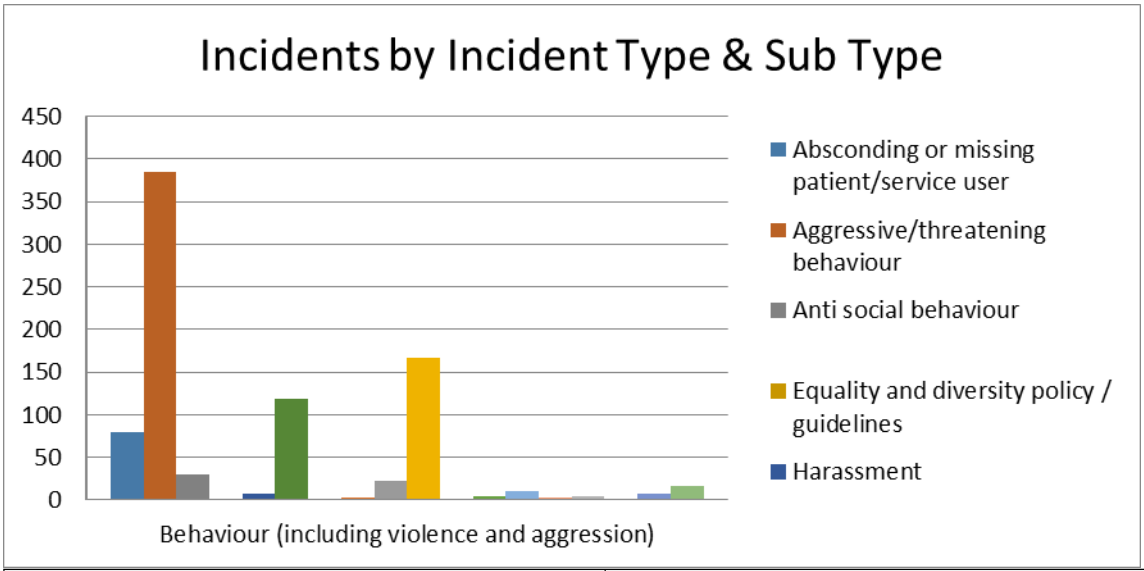
20.07.22	Ward 3	Y	72%	
21.07.22	Trefeirian Day Centre, Denbigh	Y	Part1	Part 1
22,07.22	Catering Denbigh	Y	76.60%	
26.07.22	Corridor E Outpatients	Y	34.80%	
27.07.22	Nant Y Glyn MHLD	Y	45.70%	
28.07.22	Catering YGC	Y	90.20%	
03.08.22	Ward 1 YGC	Y	82%	
05.08.22	NWAS Catering	Y	84.90%	
10.08.22	Linen Distribution	Y	30.80%	
12.08.22	Clinical Psychology	Y	20%	

18.08.22	POAC ILB YGC	Y	60%	
15.09.22	Ward 6 abh	Y	89%	
21.09.22	Ward 5	Y	53.30%	
22.09.22	Ward 4	Y	38.40%	
23.09.22	Hafod MHLD	Y	57.60%	
27.09.22	Ward 11 YGC	Y	87%	
27.09.22	Urology Secretaries Office YGC	Y	60%	
30.09.22	Chapel - YGC Part - 1	Y	45.10%	

West

01/07/2022	Intensive Care Unit, YG	Y	90.40%	
01/07/2022	High Dependency Unit, YG	Y	90.40%	
04/07/2022	COVID Vaccination Service West	Y	87.80%	
04/07/2022	Conwy Ward YG	Y	81.30%	
29/07/2022	Labour Ward, YG	Y	72.20%	
29/07/2022	Llifon Ward, YG	Y	78.30%	
29/07/2022	Midwifery Led Unit, YG	Y	72.20%	
01/08/2022	Taliesin Ward, Hergest Unit, YG	Y	80%	
03/08/2022	Mesen Fawr BYN	Y	61.70%	
04/08/2022	Infection Control and Prevention West, YG	Y	33.30%	
10/08/2022	Psychiatric Liaison Team, YG	Y	33.80%	
12/08/2022	Tudno Ward, YG	Y	44.20%	
15/08/2022	Moelwyn Ward, YG	Y	74.40%	
17/08/2022	Hospital Management Team, YG	Y	57.30%	
18/08/2022	Glyder Ward, YG	Y	70%	
06/09/2022	Switchboard, YG	Y	46.10%	
01/09/2022	Catering Dept H&S review	Y	80.7	
02/09/2022	Pharmacy Dispensary H&S review	Y	79.30%	
09/09/2022	Mortuary, YG	Y	74.40%	

Appendix Three, Violence and Aggression incidents



Absconding or missing patient/service user	79
Aggressive/threatening behaviour	385
Anti-social behaviour	30
Equality and diversity policy / guidelines	1
Harassment	8
Inappropriate behaviour / attitude	118
Inappropriate use of social media	2
Indecent exposure	3
Patient clinically challenging behaviour	23
Physical assault (physical contact)	166
Protest	4
Restrictive practices	59
Self-harm / self-injurious behaviour	324
Sexual (inappropriate) behaviour	11
Sexual assault	3
Smoking	5
Verbal assault (racial abuse)	8
Verbal assault (swearing etc.)	17

Appendix Four, Manual Handling Training Q2

Central	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
July	Patient refresher	203	186	143	43	1	not on ESR
	Teams	36	30	24	6	0	
	Foundation	27	27	27	10	0	
	Total	**266**	**243**	**194**	**59**	**1**	
	Several classes covered by West trainers during July						
	4 x Bespoke Sessions: C.Bay / Holywell CH / ITU/Porters						

Central	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
August	Patient refresher	257	207	143	64	0	
	Teams	37	37	36	1	0	
	Foundation	61	58	50	8	0	
	Total	**355**	**302**	**229**	**73**	**0**	
	3 x Bespoke: Theatres						

Central	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
Sept	Patient refresher	170	146	99	47		
	Teams Day 1	36	36	28	8		
	Foundation Day 2	25	24	16	8		
	Load Handling	0	0	0	0		
	Total	**231**	**206**	**143**	**63**		
	Bespoke						

West	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
July	Patient refresher	167	147	100	47	0	
	Teams	34	30	28	2	0	
	Foundation	38	35	28	7	0	
	Total	**239**	**212**	**156**	**56**	**0**	
	West trainers covered classes in Central						
	3 Bespoke sessions: 2 x District Nurses/MSU ByN						

West	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
August	Patient refresher	158	132	94	40	1	covid +
	Teams	36	36	33	3		
	Foundation	38	33	30	3	1	covid +
	Total	**232**	**201**	**157**	**46**		
	1 x Bespoke Tywyn						

West	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
Sept	Patient refresher	189	182	128	54		
	Teams Day 1	31	28	18	10		

	Foundation Day 2	37	37	27	10		
	Load Handling	0	0	0	0		
	Total	**257**	**247**	**173**	**74**		
	Bespoke						

East	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
July	Patient refresher	192	190	144	46	0	
	Teams	36	44	35	9	0	
	Foundation	36	35	29	7	0	
	Total	**264**	**269**	**208**	**62**	**0**	

4 Bespoke sessions: 2 x Diana Nurses / Nightingale House/Paediatrics

East	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
August	Patient refresher	110	106	68	35		
	Teams	36	36	28	6		
	Foundation	37	34	34	0		
	Total	**183**	**176**	**130**	**41**		

Bespoke x 2	champions x3	Load x4	

East	Course	Seats Offered	Booked	Attendees	DNA's	CXD classes	Reason
Sept	Patient refresher	144	131	82	49	0	
	Teams Day 1	40	40	33	7	0	
	Foundation Day 2	35	35	28	7	0	
	Load Handling	16	16	14	2	0	
	Total	**235**	**222**	**157**	**65**	**0**	
	Bespoke	**1 Patient refresher bespoke**					

Appendix Five, Fit Testing Data

Area	Jul-22	Number of Tests	No. of DNA
Central		106	17
Central Area		0	0
East		39	11
East Area		0	0
West		149	5
West Area		32	10
Total:		326	43

Area	Aug-22	Number of Tests	No. of DNA
Central		127	56
Central Area		0	0
East		101	40
East Area		58	34
West		127	51
West Area		0	0
Total:		413	181

Area	Sep-22	Number of Tests	No. of DNA
Central		160	17
Central Area		194	0
East		94	32
East Area		133	48
West		64	10
West Area		15	0
Total:		660	107

The Nurse Staffing Levels (Wales) Act – Quality Review

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

Introduction / Background

Section 25B of the Nurse Staffing Levels (Wales) Act 2016 applies to adult acute medical inpatients wards; adult acute surgical inpatient wards; and paediatric inpatient wards.

The Act has two key requirements:

1. **A duty to calculate and take steps to maintain nurse staffing levels**
2. **Apply triangulated methodology to nurse staffing level calculations i.e. Professional Judgement / Patient Acuity / Quality Indicators**

In line with the Act, nurse staffing calculations are to be approved by a ***designated person*** who is authorised to undertake this calculation on behalf of the Chief Executive Officer. The designated person should be registered with the Nursing and Midwifery Council and have an understanding of the complexities of setting a nurse staffing level in the clinical environment. Within Welsh Health Boards the designated person is the Executive Director of Nursing.

Statutory calculations of nurse staffing levels across wards pertaining to Section 25B take place between March/April (reporting to Board in May) and August/September (reporting to Board in November).

Section 25C: Nurse staffing levels: method of calculation

Section 25C of the Act describes the triangulated method of calculation that must be used for calculating the nurse staffing levels. The triangulated methodology involves collecting, reviewing and interpreting data relating to:

- **Professional Judgement** - applying knowledge, skills and experience in a way that is informed by professional standards, law and ethical principles to develop a decision on the factors that influence clinical decision making

- **Patient Acuity** - an estimate of the amount of care a patient requires based on the intensity, complexity and unpredictability of their holistic needs. In Wales the Welsh Levels of Care is the tool used to assist nurses in measuring the acuity and dependency of their patients.

- **Quality Indicators** – a measure of factors that relate to the delivery of nursing care and are used to demonstrate whether the department delivers good outcomes for patients and staff.

During the process of calculating the nurse staffing levels using the triangulated approach there is no pre-determined hierarchy in terms of the evidence with equal weighting given to all the information that informs this process. The designated person will make the determination of the nurse staffing levels based on an analysis of all the information collected about the ward and the contributions of those staff involved in the process.

Nurse Staffing Levels Calculations Process

Ward Level Data Collection & Review

Ward Manager presentations to Associate Director of Nursing/Director of Nursing outlining ward acuity/care quality indicators/and applied professional judgement.

Discussion takes place regarding current workforce issues/temporary staffing usage/future workforce needs/staff development & innovation.

Health Board Wide Multi-site, Service Specific Reviews

A Health Board wide (multi-site) review is undertaken to ensure a consistent approach, share good practice/lessons learned/opportunity to improve patient care pathways.

Autumn 2022 reviews were undertaken during the week commencing 12th September.

Review & Approval by Designated Person

Formal presentations made to the Executive Directors of Nursing and Midwifery 31/10/2022. In attendance were nominated deputies for Executive Directors Workforce & Organisational Development; & Finance

Agreed Nurse Staffing Level calculations formally presented to the Board 24/11/2022.

All Wales Acuity Audit

Acuity Audit data

During the months of January and June each year a national acuity audit is held as directed by the Chief Nursing Officer. The acuity audit is used to collect data relating to patient acuity, patient flow and nurse staffing levels.

Patient acuity is assessed using the Welsh Levels of Care evidence-based workforce planning tool. This measure of patients levels of acuity indicates how much care is required in order to determine the nurse staffing level that is required to meet reasonable requirements of care.

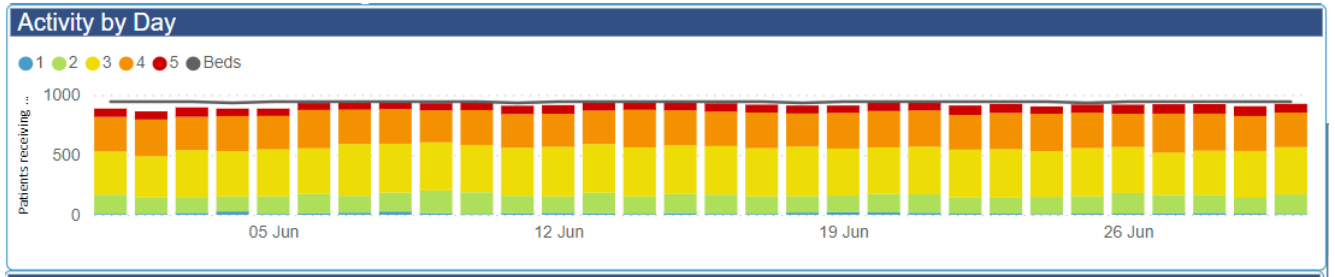
This information when used as part of a triangulated approach alongside the use of quality indicators and professional judgement will determine the nurse staffing level for the ward.

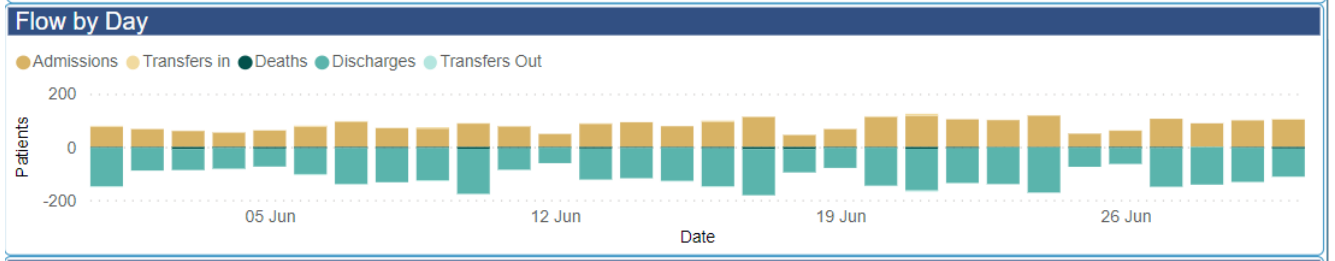
Welsh Levels of Care

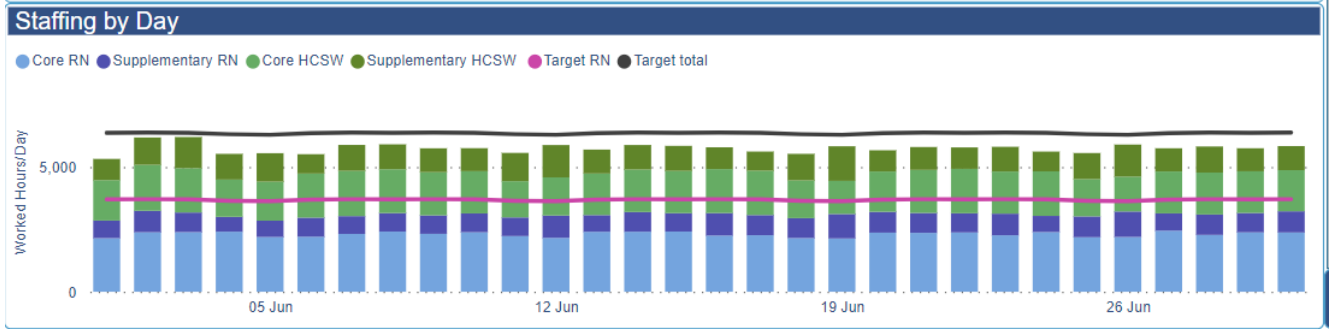
The Welsh Levels of Care are summarised below, further detailed information can be found **here**

Level 5	**One to One Care** - the patient requires at least one to one continuous nursing supervision and observation for 24 hours a day
Level 4	**Urgent Care** - The patient is in a highly unstable and unpredictable condition either related to their primary problem or an exacerbation of other related factors.
Level 3	**Complex Care** - The patient may have a number of identified problems, some of which interact, making it more difficult to predict the outcome of any individual treatment
Level 2	**Care Pathways** - The patient has a clearly defined problem but there may be a small number of additional factors that affect how treatment is provided.
Level 1	**Routine Care** - The patient has a clearly identified problem, with minimal other complicating factors.

BCUHB June 2022 Acuity Audit data







Please note - data presented does not include Enlli ward as they did not participate in this acuity audit and Alaw as due to technical issues their data is not available.

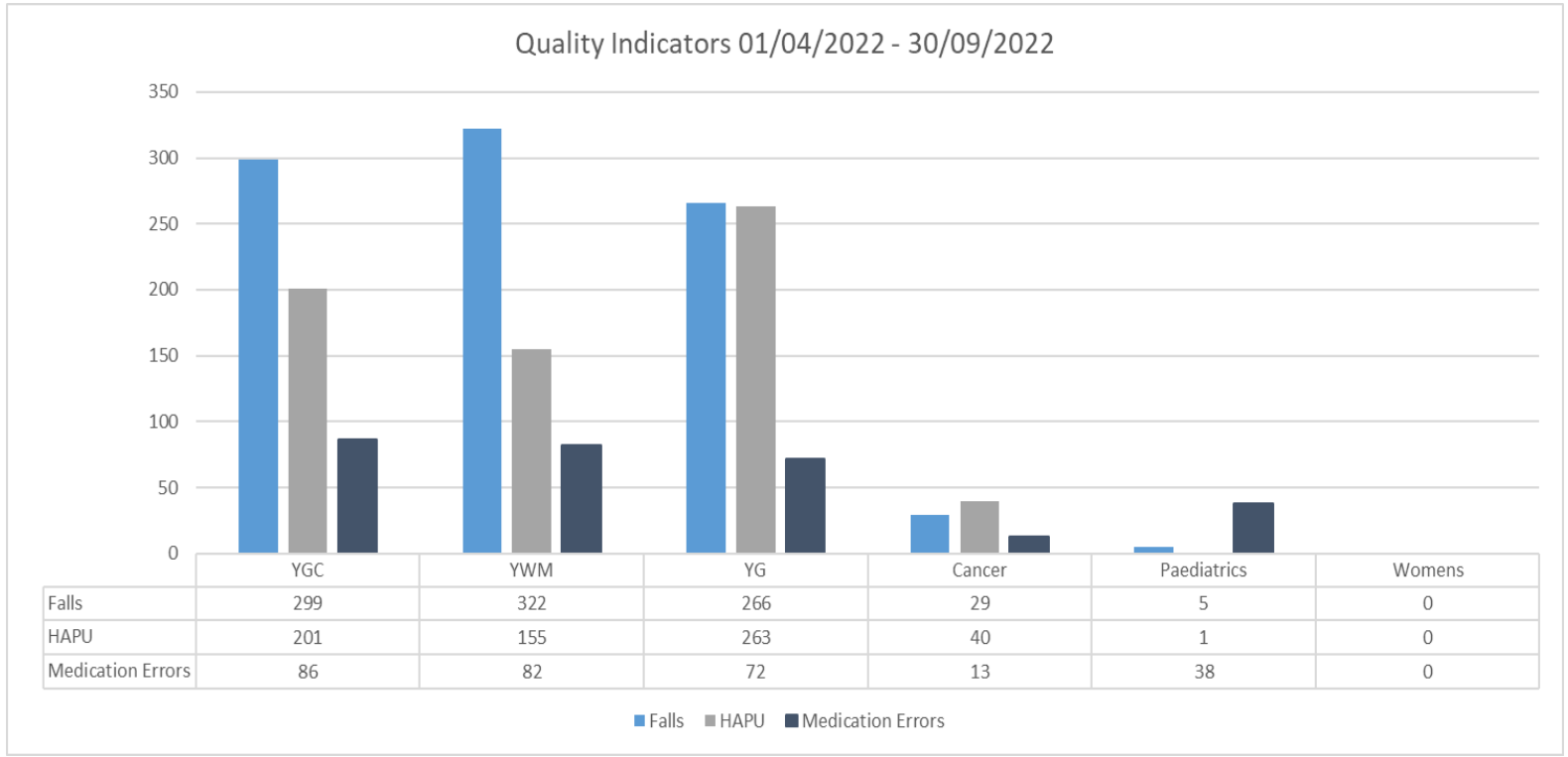
Data Source – HCMS System

Quality Indicators sensitive to care provided by a nurse

Nurse staffing level calculations must take into account:

- pressure ulcers
- medication administration errors
- patient falls
- infiltration / extravasion injuries (paediatric wards)

Other indicators that are sensitive to nurse staffing levels may also be considered, such as complaints



	YGC	YWM	YG	Cancer	Paediatrics	Womens
Falls	299	322	266	29	5	0
HAPU	201	155	263	40	1	0
Medication Errors	86	82	72	13	38	0

The chart above details by Integrated Health Community / division the total number of patient falls, pressure ulcers and medication errors recorded within DATIX for the period 01/04/2022 – 30/09/2022. No Infiltration/Extravasation injuries were reported during this period.

Data is based on only those wards to which Section 25B of the 2016 Act pertains.

Approved Nurse Staffing Levels – Autumn 2022 (summary)

The nurse staffing level calculations undertaken during this reporting period (October 2021 – September 2022) identified a number of wards that require a change to their establishments with the overall proposed FTE changes summarised in the table below:

Integrated Health Community	Number of Act Wards	Funded Bed Numbers	Required Establishment at the start of the reporting period (October 2021)		Required Establishment at the end of the reporting period (September 2022)		Staffing FTE Changes during reporting period 2021-2022		Funded* Establishment (as at October 2022)		FTE Variance between current funded (October 2022) and required (September 2022)	
			RN	HCA	RN	HCA	RN	HCA	RN	HCA	RN	HCA
YWM	14	327	268.83	208.52	277.14	219.9	8.31	11.38	272.68	178.8	4.46	41.1
YG	10	233	209.54	172.8	207.51	195.71	-2.03	22.91	196.46	138.62	11.05	57.09
YGC	13	310	276.53	238.53	261.51	253.56	-15.02	15.03	254.13	176.72	7.38	76.84
Oncology & Haematology**	2	39	N/A	N/A	33.3	31.27	33.3	31.27	33.61	26.74	-0.31	4.53
Womens Gynaecological**	1	14	N/A	N/A	11.37	5.69	11.37	5.69	11.93	6.32	-0.56	-0.63
Paediatric Inpatient Wards	3	64	83.46	31.27	83.46	31.27	0	0	79.47	30.37	3.99	0.9
BCUHB Total	**43**	**987**	**838.36**	**651.12**	**874.29**	**737.4**	**35.93**	**86.28**	**848.28**	**557.57**	**26.01**	**179.83**

*Funded establishment sourced from Finance Ledger
** Establishment in place pre meeting the definition pertaining to Section 25B
Note: The required and funded establishment figures exclude supernumerary ward sister/charge nurse and ward support staff i.e. housekeepers, dementia support workers etc.

Section 25B wards requiring a change to nurse staffing levels

During this reporting period (October 2021 – September 2022) 23 wards requested changes to their establishments.

The summary of changes approved or unsupported following the review by the Executive Director of Nursing are summarised in the table below:

Integrated Health Community	Number of Act Wards	Wards Requesting Adjustments	Adjustments Approved by Exec DoN	Adjustments Unsupported by Exec DoN	Comments
YWM	14	8	4	3	Bersham - a request to increase HCA staffing was not supported at this time, as acuity and quality indicators did not indicate a change was required. This request will be revisited in the Spring 2023 reviews. Morris - requested an increase in nurse staffing levels to support x 6 escalated beds. Change to establishment unsupported at this time and site HMT advised to submit a scheme to IMPT for the permanent funding of these beds. Pantomime - requested an increase in nurse staffing levels to support x 6 escalated beds. Change to establishment unsupported at this time and site HMT advised to submit a scheme to IMPT for the permanent funding of these beds.
YG	10	9	9	0	0
YGC	13	7	6	1	Ward 3 - a request to increase in RN staffing not supported at this time, as acuity and quality indicators did not indicate a change was required. This request will be revisited in the Spring 2023 reviews.
Oncology & Haematology	2	2	0	0	0
Womens Gynaecological	1	1	0	0	0
Paediatric Inpatient Wards	3	0	0	0	0
BCUHB Total	**43**	**23**	19	**4**	**0**

Example of Fully Approved Ward

Ward 1 YGC

Ward 1 is a 24 bedded COTE ward in Ysbyty Glan Clywd

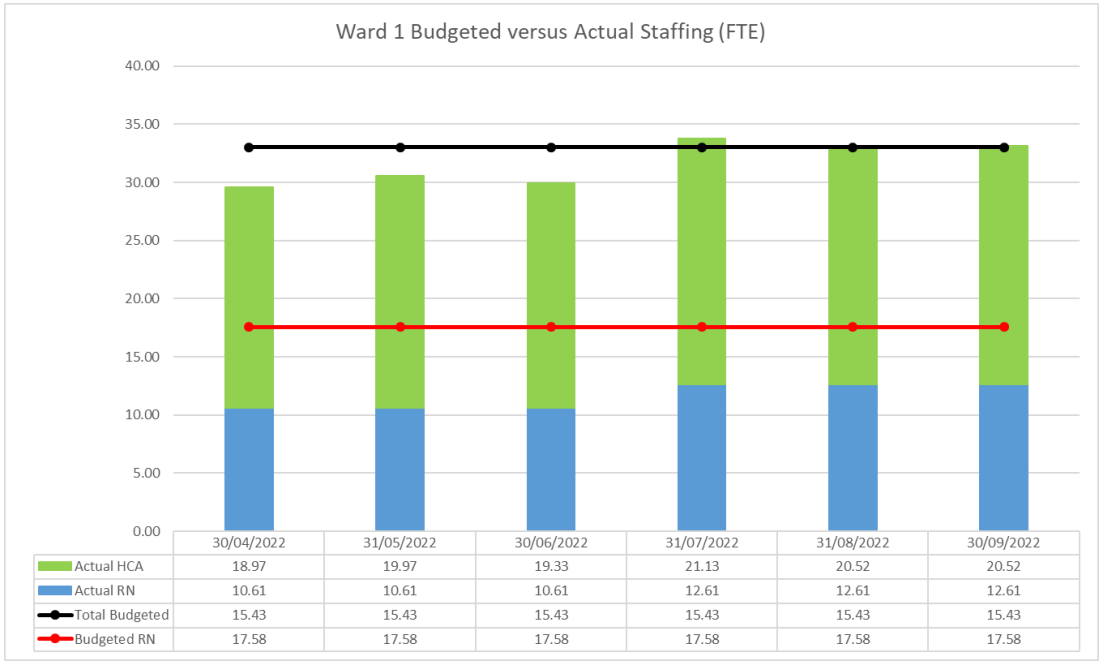
	Early		Late		Twilight		Night		Change Request Rational
	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Staffing at start of reporting period (October 2021)	4	4	4	4	0	1	3	3	Autumn 2022 review required an increase in HCA staffing during the day to support patient care acuity and harms profile.
Staffing agreed following Spring 2022 review	4	4	4	4	0	1	3	3	
Staffing requested at Autumn 2022 review	4	5	4	5	0	1	3	3	
Staffing agreed at end of reporting period (September 2022)	4	5	4	5	0	1	3	3	

During the staffing review it was established that the ward had RN vacancies, backfilled with HCA staff which meant that although overall vacancies were low there was an identified issue with skill mix on the ward. An action plan was in place regarding this which also included overseas nurses who were awaiting NMC PIN and currently working in Band 4 posts. Sickness absence on the ward was within BCU targets.

The ward had seen an increase in patient care acuity and also patient falls and were requesting additional HCA staffing during the day to support with this, having currently been utilising temporary staffing to support. On review the data and professional judgement supported the need for the increase in staffing to be agreed.

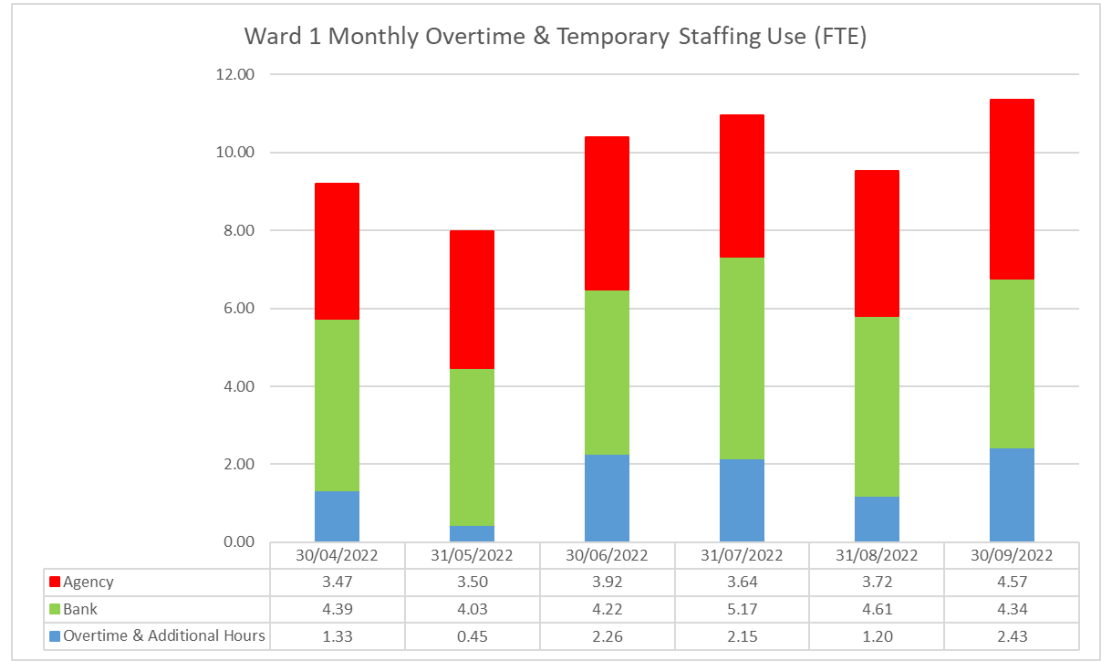
Ward 1 Staffing Data

Ward 1 staffing data demonstrates that the ward has significant RN vacancies over the months preceding the Autumn review, however overall staffing is in line with budget. Staffing reviews identified that a plan is in place regarding the skill mix.



	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Actual HCA	18.97	19.97	19.33	21.13	20.52	20.52
Actual RN	10.61	10.61	10.61	12.61	12.61	12.61
Total Budgeted	15.43	15.43	15.43	15.43	15.43	15.43
Budgeted RN	17.58	17.58	17.58	17.58	17.58	17.58

Ward 1 temporary staffing data demonstrates a sustained use in temporary staffing over the reporting period which is reflective of the need for additional staffing to meet increased patient acuity care needs.

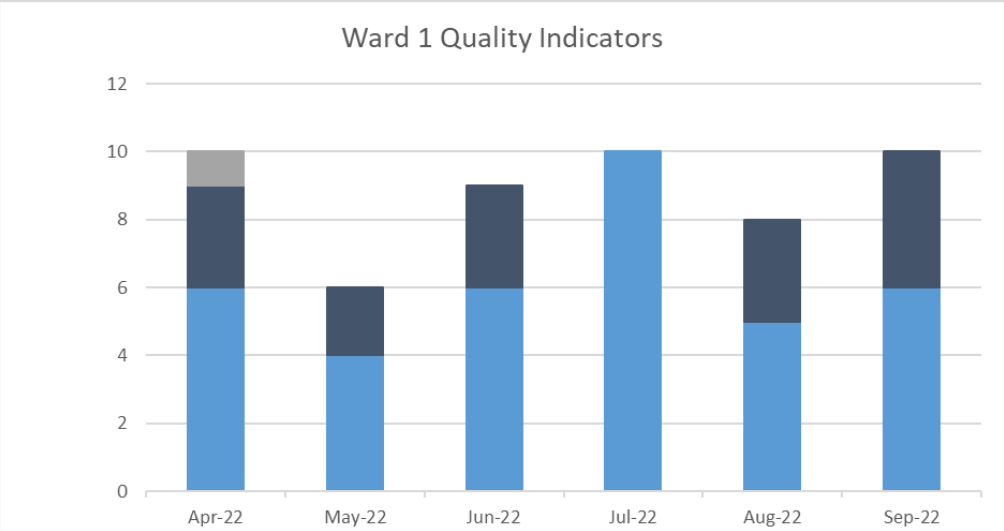


	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Agency	3.47	3.50	3.92	3.64	3.72	4.57
Bank	4.39	4.03	4.22	5.17	4.61	4.34
Overtime & Additional Hours	1.33	0.45	2.26	2.15	1.20	2.43

Data Source – WOD Workforce Dashboard

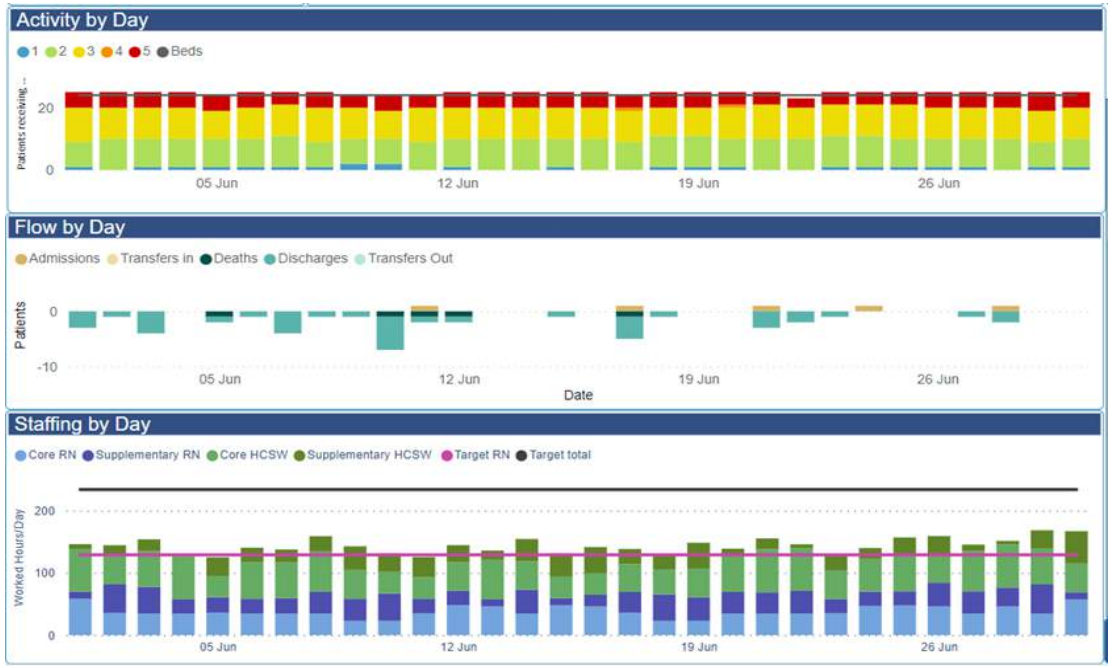
Ward 1 Patient Data

Ward 1 quality indicator data demonstrates a relatively consistent number of falls over the review period



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medication	1	0	0	0	0	0
HAPU	3	2	3	0	3	4
Falls	6	4	6	10	5	6

Ward 1 acuity data evidences the reported increase in patient acuity with higher levels of patients requiring Level 5 (one to one care) with an average of 5 patients a day requiring the highest levels of care



Data Source – Datix & HCMS Systems

Example of Partially Approved Ward

Tryfan YG

Tryfan is a 24 bedded gastro ward in Ysbyty Gwynedd

	Early		Late		Twilight		Night		Change Request Rational
	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Staffing at start of reporting period (October 2021)	4	4	4	4	0	0	3	3	RN & HCA staffing had been adjusted during Spring 2022 review following a skill mix review and in response to harm profile to be Early 4/5 Late 4/5 Night 3/3. Further increase of HCAs requested in Autumn review due to patient care acuity and harm profile.
Staffing agreed following Spring 2022 review	4	5	4	5	0	0	3	3	
Staffing requested at Autumn 2022 review	4	6	4	6	0	0	3	3	
Staffing agreed at end of reporting period (September 2022)	4	5	4	5	0	0	3	3	

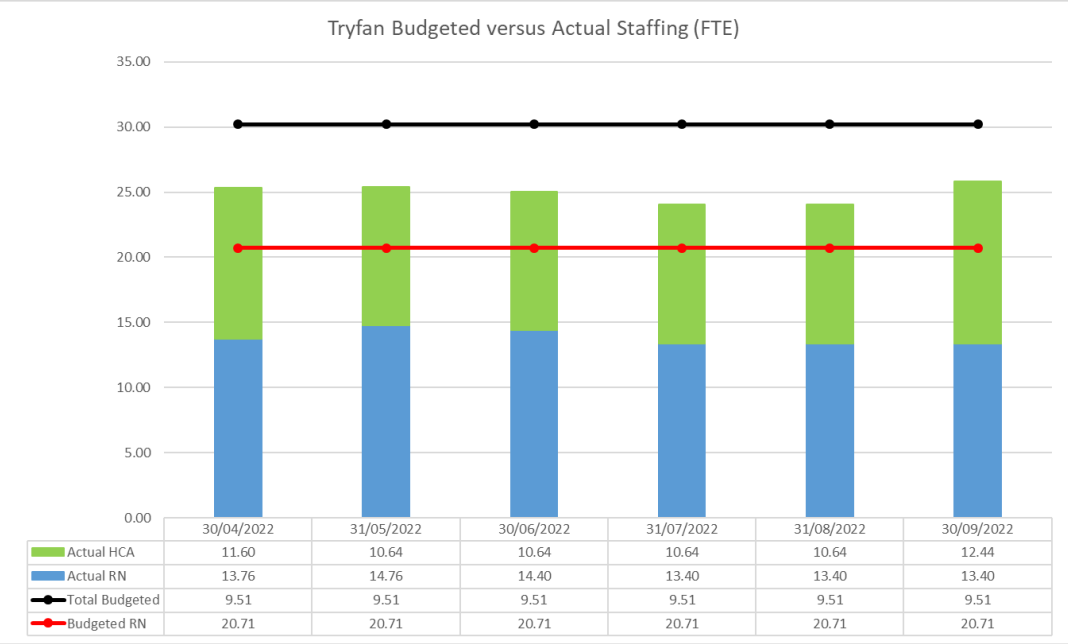
During the staffing review it was established that the ward had not achieved the increased staffing levels agreed during the Spring 2022 due to vacancies, absence levels and reliance on temporary staffing. A new Ward Manager had recently started in post and this was reported as beginning to bring some stability to the ward.

On review of the data and utilising professional judgement it was felt that the ward needed a further period of time to focus on staff recruitment and absence management and therefore the Spring 2022 staffing levels were deemed to be appropriate, with a further review due in Spring 2023.

The YG site has an ongoing improvement plan in place for Tryfan ward and will continue to monitor this.

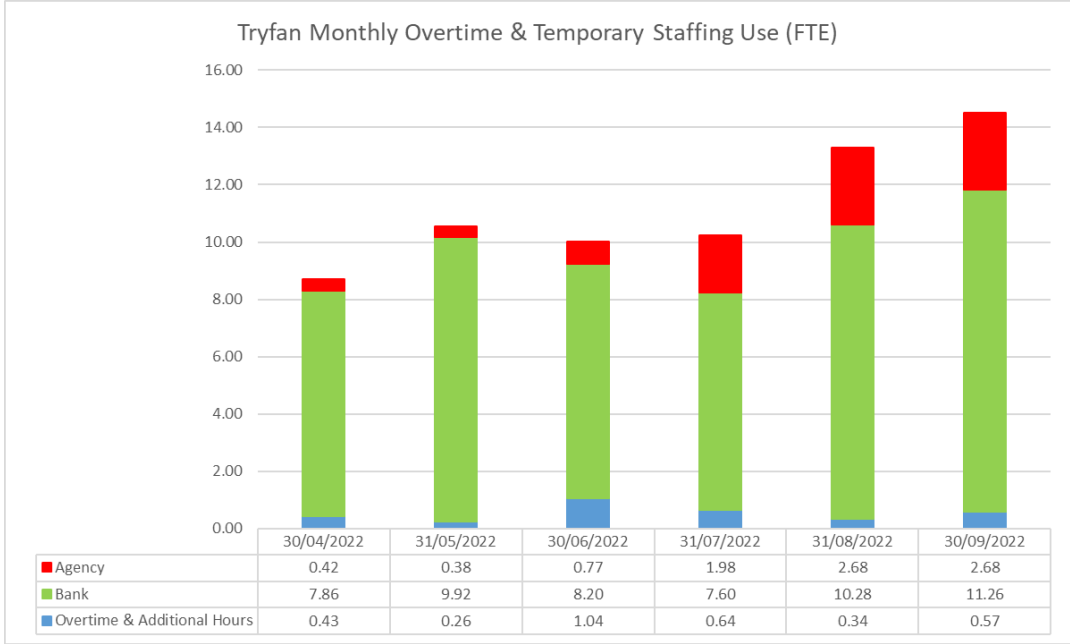
Tryfan Staffing Data

Tryfan ward staffing data demonstrates that the ward has a significant level of RN vacancies over the months prior to the Autumn review.



	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Actual HCA	11.60	10.64	10.64	10.64	10.64	12.44
Actual RN	13.76	14.76	14.40	13.40	13.40	13.40
Total Budgeted	9.51	9.51	9.51	9.51	9.51	9.51
Budgeted RN	20.71	20.71	20.71	20.71	20.71	20.71

Tryfan ward temporary staffing data demonstrates an increasing use of temporary staffing which is reflective of the vacancies within the ward.

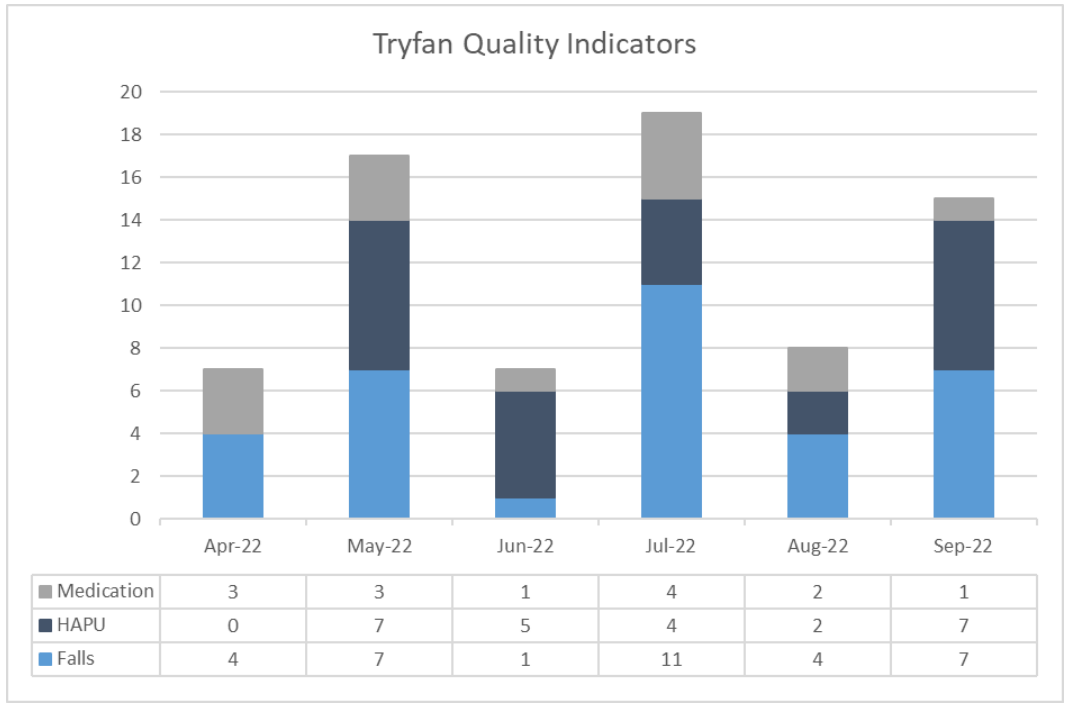


	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Agency	0.42	0.38	0.77	1.98	2.68	2.68
Bank	7.86	9.92	8.20	7.60	10.28	11.26
Overtime & Additional Hours	0.43	0.26	1.04	0.64	0.34	0.57

Data Source – WOD Workforce Dashboard

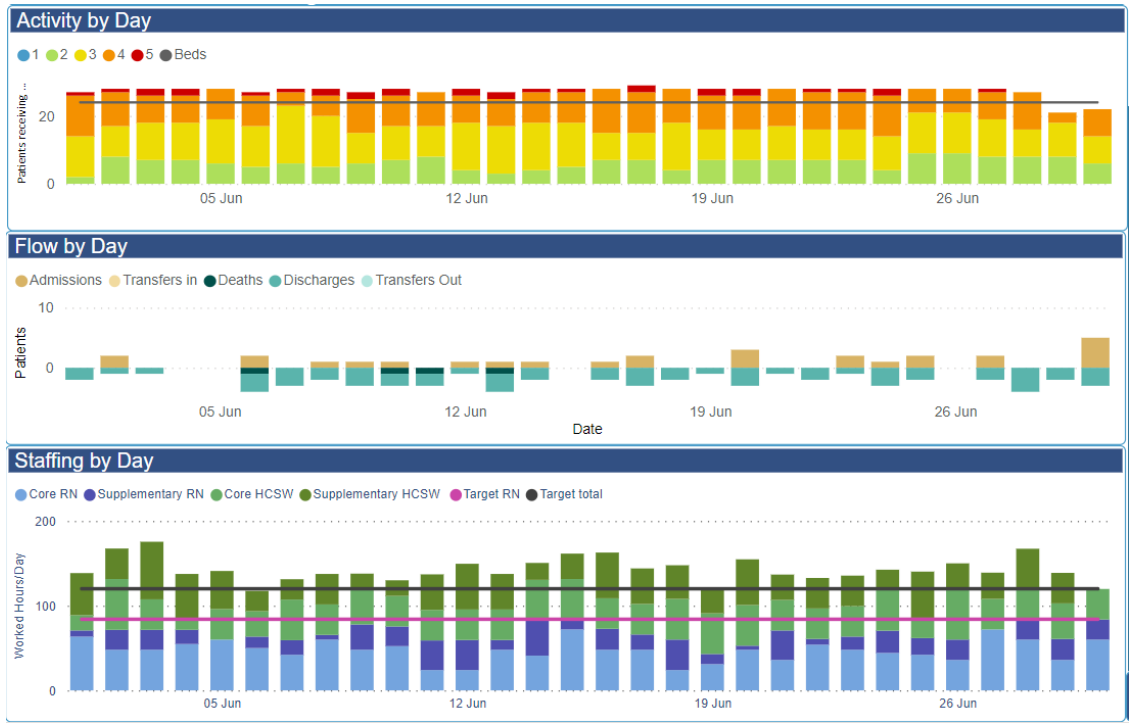
Tryfan Patient Data

Tryfan ward quality indicator data demonstrates a fluctuating number of incidents occurring throughout the review period



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medication	3	3	1	4	2	1
HAPU	0	7	5	4	2	7
Falls	4	7	1	11	4	7

Tryfan ward acuity data shows the ward has high levels of patients at level 3 (complex care) & level 4 (urgent care)



Data Source – Datix and HCMS Systems

Example of Ward with changes unsupported at time of Autumn reviews

Bersham YMW

Bersham is a 27 bedded stroke ward in Ysbyty Maelor Wrexham, comprising of 10 acute and 17 rehabilitation beds.

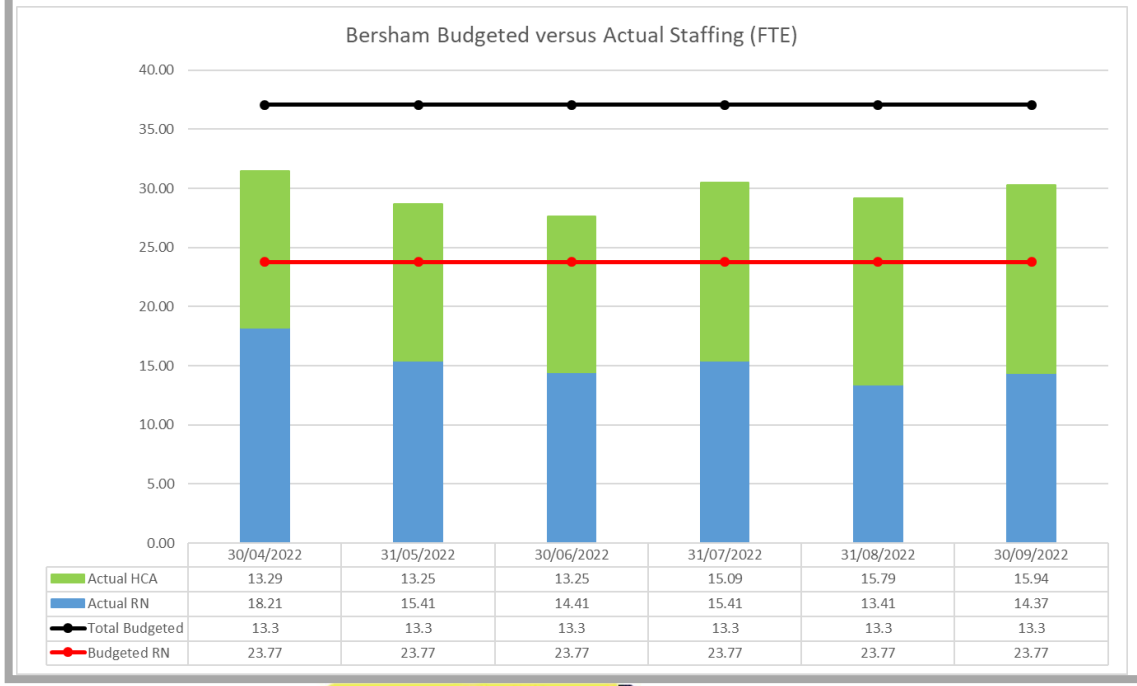
	Early		Late		Twilight		Night		Change Request Rational
	RN	HCA	RN	HCA	RN	HCA	RN	HCA	
Staffing at start of reporting period (October 2021)	5	3	5	3	0	0	4	2	Autumn 2022 review requested an increase in HCA staffing in response to harm profile
Staffing agreed following Spring 2022 review	5	3	5	3	0	0	4	2	
Staffing requested at Autumn 2022 review	5	4	5	4	0	0	4	3	
Staffing agreed at end of reporting period (September 2022)	5	3	5	3	0	0	4	2	

During the staffing review it was established that there were known issues with the ward leadership due to staffing changes and absences which had also resulted in recruitment & retention issues on the ward. The YMW site was supporting leadership; training and development of staff on the ward and there was also ongoing work relating to the BCU wide stroke services consultation process. The ward also benefits from high levels of MDT support.

On review of the data and utilising professional judgement it was agreed that the staffing levels of 5/3 5/3 4/2 were appropriate for the bed numbers (27) and comparable to the other stroke wards therefore at this time request for additional staffing was not approved. The site was advised to continue with the enhanced period of support, including falls quality work, monitor outcomes throughout and escalate issues as necessary. The ward will be reviewed further in Spring 2023.

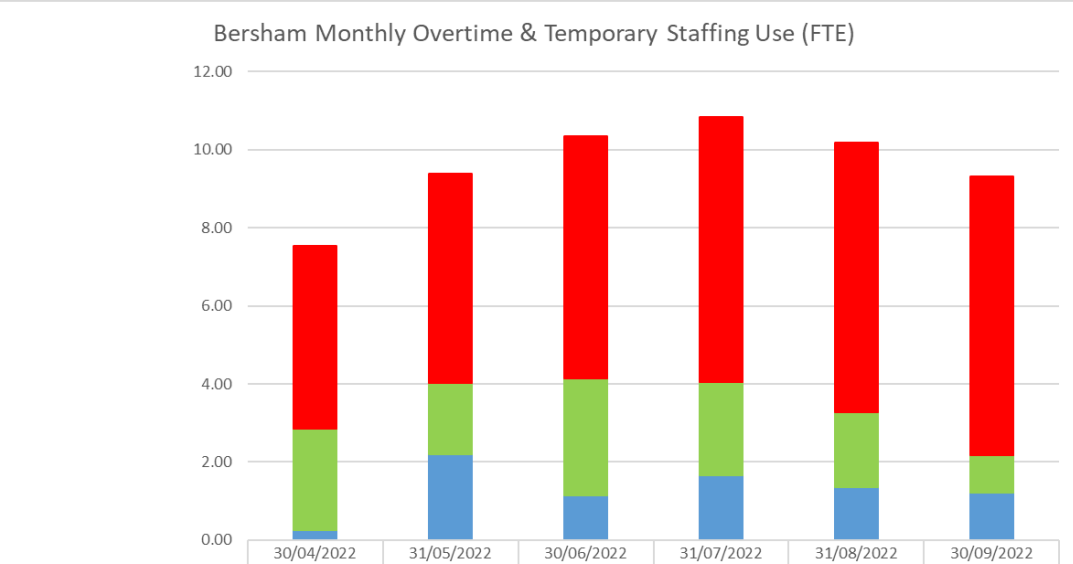
Bersham Staffing Data

Bersham ward staffing data demonstrates that the ward has a consistent and significant level of RN vacancies over the months prior to the Autumn review.



	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Actual HCA	13.29	13.25	13.25	15.09	15.79	15.94
Actual RN	18.21	15.41	14.41	15.41	13.41	14.37
Total Budgeted	13.3	13.3	13.3	13.3	13.3	13.3
Budgeted RN	23.77	23.77	23.77	23.77	23.77	23.77

Bersham ward temporary staffing data demonstrates a consistent and sustained use of temporary staffing which is reflective of the vacancies within the ward.

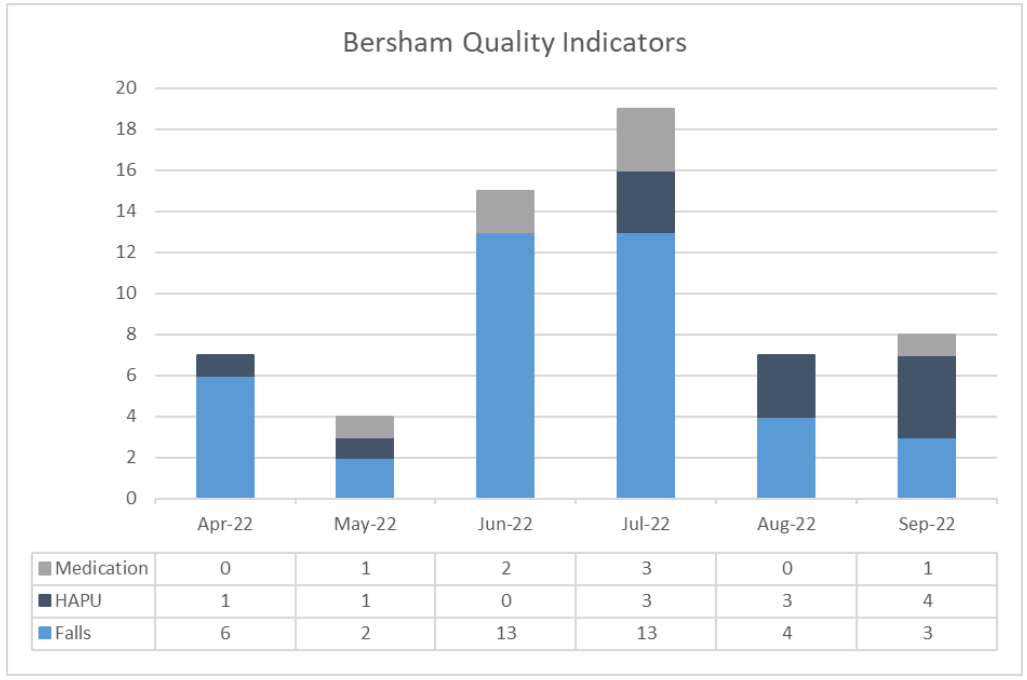


	30/04/2022	31/05/2022	30/06/2022	31/07/2022	31/08/2022	30/09/2022
Agency	4.69	5.35	6.18	6.78	6.91	7.16
Bank	2.59	1.83	3.00	2.40	1.92	0.96
Overtime & Additional Hours	0.26	2.20	1.15	1.66	1.36	1.20

Data Source – WOD Workforce Dashboard

Bersham Patient Data

Bersham ward quality indicator data demonstrates a fluctuating number of incidents occurring throughout the review period



	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Medication	0	1	2	3	0	1
HAPU	1	1	0	3	3	4
Falls	6	2	13	13	4	3

Bersham ward acuity data shows the ward has high levels of patients at level 4 (urgent care) with a significant number of patients requiring level 5 (one to one care).

Data Source – Datix and HCMS Systems

Recommendations

Office of the Executive Nurse Director:

- Continue to review the impact of nurse staffing within the clinical areas and quality metrics.
- Continue to work closely with clinical teams to review any correlation between clinical incidents and the number of red flags being raised.
- Continue with the work underway to link the Quality and Workforce metrics to enable review of the data (Exec. Nurse Dashboard)
- Continued focus on recruitment and retention and innovation to support workforce utilisation and reporting.

Diolch / Thank you

Any questions?

Quality, Safety & Experience Committee 20.01.23	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 (SOHS) Group

Meeting date:	22 November 2022

Name of Chair:	Sue Green, Executive Director of Workforce and Organisational Development Acting Chair, Peter Bohan, Associate Director of Health, Safety and Security

Responsible Director:	Sue Green, Executive Director of Workforce and Organisational Development

Summary of key items discussed:	<u>Patient Handling / Falls Risk Assessments</u> An update was provided to the SOHS group on the progress of the bedside learning in terms of improving BCUHB compliance with the Falls and Bone Health, Multifactorial Risk Assessment and the Patient Handling risk assessment following the improvement notices received from the HSE. The aim of the learning is to improve the quality of the risk assessments and to reflect more accurately, the interventions stated in this paperwork within adult inpatient services. A test of staff knowledge and practice was undertaken earlier this year, which reflected on the quality of the paperwork and the barriers to completing it fully. Bedside learning was then completed, one to one, with staff members and an improvement in the completion of these risk assessments was seen with a change of mind set in staff evident. The initial plan was for the bedside learning to be rolled out across all the IHCs by Corporate Nursing, with support from the H&S and Patient Handling teams, but this has stalled due to the recent pressures within the wards and IHCs as a whole. The plan now is to roll out the bedside learning in high-risk areas in Ysbyty Gwynedd, with support from the H&S and Patient Handling teams, including members of the IHCs. The plan was waiting to be signed off at the Strategic Falls Group. <u>Lifting Equipment</u> Following recent incidents where fire and rescue services have been called to assist with fallen patients, lifting equipment is required for all sites. It has been assessed that the three DGH's require Hoverjack lifting equipment and the community hospitals require (Manga Elks) these are used to lift patients from the floor safely, minimising the risks of manual handling. There is a group meeting to progress these requirements.

	IOSH leading safely Courses have been booked in December and January for staff band 8D or equivalent and above. There is a requirement for 85% of the Health Board Leadership Team to attend by the end of January 2023 and 95% of all staff at this level by the end of July 2023. Estates Update An overview of the subgroups reporting to the Pan BCUHB Estates Health and Safety Group was provided. A RIDDOR reportable case of hand-arm vibration syndrome has been sent to the HSE which will require an investigation. 16 Estates staff have now attended IOSH Managing Safely courses and senior leadership staff have been identified to attend the IOSH Leading Safely course. The 10 year Radon surveys are due for across BCUHB. Tier 1 estates risks include asbestos management, control of contractors, legionella management and fire safety systems. The tier 2 entry for infrastructure needs to be escalated due to the lack of available capitol funding. The Sypol COSHH management system will go live in January 2023 and the SHE software system for contractor management will go live in April 2023. The LEV system in BYN posture and mobility workshops should have been replaced following an HSE investigation and this was escalated for further updates to come back to the next meeting. Site Leads It was noted that on some of the community hospital sites or other BCUHB buildings there is no site lead to take responsibility for health and safety, fire, security, legionella etc. It was agreed that this needs to be considered by Directors planning their new structures. Health and Safety Leads Group Item for escalation from this group was a lack of communication around the change of sharps containers that could potentially see a rise in sharps related injuries. This will be monitored through Datix and Occupational Health referrals and escalated back to the SOHS Group if there was a rise in incidents. COSHH Forum Items for escalation from the COSHH forum included a lack of a BCUHB Formalin policy, current and proposed storage of liquid nitrogen in YG and YGC and meetings having low attendance. A report will be provided to the next Strategic Occupational Health and Safety group for progress. Divisional Reports Divisional reports were provided from East IHC, West IHC, MHLD and Women's services. Policies / Guidance The SOHS group, with agreed changes to be completed after the meeting, ratified the Lone Working Guidance. The Working at Height guidance was tabled for final consultation.

Key advice / feedback for the QSE Group:	Security Management Group The new Security Management Group had their first meeting on the 7th of November and a Chairs report was provided to the SOHS Group. The items for escalation included: - Security Guarding Service Level Agreements (SLA): The core security guarding SLA for the two guards 24/7 on the three DGH sites is managed by the Corporate Health and Safety team. However, any additional guards required e.g. bed watch and infection control guards at the entrances requires sites to set up their own SLA with the security guard provider, these are still outstanding. - CCTV Procedure; the CCTV policy has been ratified and requires site specific standard operating procedures to clearly identify who is authorised to view the CCTV systems. There is a template available and this has been circulated for completion however, none have been returned yet. Flu Immunisation Programme It was escalated that the current uptake of flu vaccinations is 35.59% across BCUHB with a further 8,600 vaccinations to reach the target 85%. Potential barriers discussed included a lack of access to book on BetsiNet, peer vaccinators not being released due to site pressures, late promotional material from Welsh Government and MVCs offering only a double vaccination (with COVID) following a WG instruction, which may not be wanted. The Occupational Health team are focusing on vaccinating staff and have sessions available now to book.
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 ▪ A review of the past 12 months HSE enforcement action ▪ Amended terms of reference to be agreed in line with the Strategic Occupational Health and Safety Group
Date of next meeting:	To be confirmed

Disclosure:
Betsi Cadwaladr University Health Board is the operational name of Betsi Cadwaladr University Local Health Board

Teitl adroddiad: ***Report title:***	Chair's Assurance Report from Clinical Effectiveness Group (CEG)		
Adrodd i: ***Report to:***	Quality, Safety and Experience (QSE) Committee		
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023		
Crynodeb Gweithredol: ***Executive Summary:***	The paper describes recent changes to the structure and function of the Clinical Effectiveness Group (CEG) designed to ensure high performance across the new operating model. The paper describes new opportunities for research into clinical effectiveness and success at the recent Health Hacks award. The paper describes key learning from the work of the Reducing Avoidable Mortality Group (RAMG) and how these will be used to change practice. The paper updates on changes to policies related to consent. The paper explains how the newly established NICE (National Institute for Clinical Excellence) assurance group will influence care. The paper discusses how clinical pathways outside of the Transformation and Improvement programme will be approved. The paper describes the challenges being reported by some clinical teams to complete Tier One audits.		
Argymhellion: ***Recommendations:***	The Committee is asked to note the content of the report and the interaction of various workstreams which contribute to clinical effectiveness. The committee is asked to note that the Human Tissue Authority working group (HTA) now reports to the Patient Safety and Quality Group (PSCQ). The committee is asked to note the challenges reported by some operational units to deliver Tier 1 audits and how the CEG is responding to this.		
Arweinydd Gweithredol: ***Executive Lead:***	Dr Nick Lyons, Executive Medical Director		
Awdur yr Adroddiad: ***Report Author:***	Dr Karen Mottart, Acting Deputy 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 *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*
Some clinical services are reporting that they do not have sufficient clinical resource to complete the Tier One audits. The CEG is directing operational units to identify the gaps and develop plans to mitigate these gaps. This will require additional investment in the services or re-allocation of priorities.				
Cyswllt ag Amcan/Amcanion Strategol: ***Link to Strategic Objective(s):***	Delivery of high-quality clinical care and patient experience			
Goblygiadau rheoleiddio a lleol: ***Regulatory and legal implications:***	None			
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?***	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 been 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)***	There are no specific risks associated with the delivery of clinical effectiveness.			
Goblygiadau ariannol o ganlyniad i roi'r *argymhellion ar waith* ***Financial implications as a result of implementing the recommendations***	There are no direct financial costs associated with this update. Individual projects or pathways may generate added cost pressures, but these are dealt with in the operational delivery teams.			
Goblygiadau gweithlu o ganlyniad i roi'r argymhellion ar waith ***Workforce implications as a result of implementing the recommendations***	There are no current workforce implications associated with the delivery of clinical effectiveness but they may be identified during the process undertaking reviews			
Adborth, ymateb a chrynodeb dilynol ar ôl ymgynghori	N/A			

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)*	None
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***	
List of Appendices: *Appendix 1 – Quarter 2 Audit Report*	

BOARD OF DIRECTORS MEETING IN PUBLIC
Friday, 20th January 2023 - Clinical Effectiveness Group - Chair's Report to Quality, Safety and Experience Committee (QSE)

1. Introduction

The Clinical Effectiveness Group (CEG) meets monthly. The key purpose of CEG is to ensure care is commensurate with best practice guidance and evidence. It also disseminates information linked to new pathways and treatments within the Health Board (HB). CEG receives reports from all IHCs (Integrated Health Communities) and divisions, and several key HB quality groups. Terms of reference have recently been revised and are awaiting executive sign-off.

The Clinical Effectiveness Group works closely with the Patient Safety, Patient Experience and Corporate Governance teams.

Discussions are taking place with each Integrated Health Community (IHC) and Divisional director to agree roles and responsibilities with respect to clinical effectiveness.

The role of the Divisional/IHC lead will include oversight of all Tier 1 and Tier 2 audits to support the collation of data and clear specific, measurable, action-focussed, realistic and timed (SMART) improvement plans for all areas of non-compliance.

The Clinical Audit team is currently holding fortnightly business meetings with the Acting Deputy Executive Medical Director (DEMD) to ensure we establish clear objectives and drive through the operational changes needed.

2. Body of report

Key updates from CEG since last QSE report:

The Quarter 2 Clinical Audit Report (Appendix 1) has been signed off.

The revised CEG Terms of Reference have been written and are due to be ratified by the Executive Medical Director.

Research and Development sub-group
Research studies are re-opening, and new studies are coming online post pandemic. The Research and Development team are working with Health and Care Research and NHS colleagues across Wales to develop a framework to prioritise studies and allocate resource.

BCUHB teams were successful at the Wales Health Hacks. Four winning projects were awarded £20,000 each.

Reducing Avoidable Mortality Steering Group
The Learning from Mortality Panel (LFMP) has been established for six months. Specific themes include

- end of life care
- communication
- documentation
- tertiary referral

The Associate Medical Director for Mortality is linking with teams to improve practice and pathways.

Clinical Law and Ethics
The group discussed and approved two new policies

- **MD01:** Policy on Consent To Examination or Treatment (Based on the All-Wales Model Policy)
- **MD21:** Guidance: Production of Procedure Specific Consent Forms (PSCF's)

NICE Assurance Group (NAG) subgroup
The NICE assurance process has been restructured to ensure clinical risk is identified. Specific issues have been identified within respiratory services (pulmonary rehabilitation and interstitial lung disease) and the IHCs are reviewing review how these risks can be mitigated.

Ratification of Pathways, Standard Operating Procedures and Policies

The Chair is working with leads for Transformation and Innovation and PSQG to clarify and streamline the process for ratification of new or updated pathways and policies. It is anticipated that a final HB wide process will be agreed by end of January 2023.

3. Budgetary / Financial Implications

There are no budgetary implications associated with this paper.

4. Risk Management

There are no specific additional risks associated with this paper.

5. Equality and Diversity Implications

There are none associated with this paper

Quarter 2 Report

Clinical Audit Activity 2022-2023

1.0 The National Audit Programme and Clinical Effectiveness overview

Each year, the Health Board receives notification of the National Clinical Audit and Outcome Review Plan (NCAORP) from Welsh Government (WG) which describes priority areas for completion by all Health Boards for mandatory audits; these form our Tier 1 activity. Relevant Tier 1 (National audits) must be incorporated within relevant Divisional/Directorate annual clinical audit plans. The Clinical Effectiveness Department report on progress on a quarterly basis.

From February 2022 WG took the decision that while participation in the National Audit program is mandated, submission of proformas (Part A and Part B) to WG of assurance returns was no longer required. It rests solely with the Health Board to secure and track its own compliance. We are currently reviewing the process that will outline the variance from best practice and identify local and Health Board actions required to close the variance or reduce the risks if actions are not met. The new proforma was circulated in early November 2022 and will be reviewed and reported back within the annual report.

2.0 Tier 1 Overview of Quarter 2 - Clinical Audit Activity 2022-2023

The tables below show the position on 30/09/2022 end of Quarter 2.

	Q1 Apr-Jun	Q2 Jul-Sep	Q3 Oct-Dec	Q4 Jan-Mar	Expected publication/activity 2023/2024
Estimated publications due	10	9	12	6	5
Actual publications	13	9	0	0	-
Part A due	4	16	6	11	6
Part A received	4	10	0	0	-
Part A overdue	0	6	0	0	-
Part B due	0	3	16	12	11
Part B received	0	2	0	0	-
Part B overdue	0	1	0	0	-

2.1.0 BCUHB Assurance Returns

2.1.1 <u>Part A returns</u> for Quarter 2, 2022-23. Ten (of 16) were returned as follows.
Part B responses to be received in Quarter 3.

I. NACAP: Children & Young People Asthma: Organisational report published 16/06/22 - Response provided for all three areas
II. NACAP: Pulmonary Rehabilitation: Organisational report published 14/07/22 - Response provided for all three areas
III. SSNAP (Stroke Audit): Acute Organisational report published 16/06/22 - All areas are contributing. SMART action plans from each area awaited.
IV. National Audit of Care at the End of Life: report published 14/07/22 – Response provided by Palliative Care for all three areas. Await SMART action plan on completion of part B form.
V. National Heart Failure Audit: report published 16/06/22. Part A received
VI. Cardiac Rhythm Management: report published 16/06/22. Part A received
VII. PCI Audit: report published 16/06/22 - Part A received on time 11/08/2022
VIII. MINAP: report published 16/06/22 - Part A received on time 11/08/2022
IX. National Maternity and Perinatal Audit: report published 16/06/22 - Part A received on time 11/08/2022
X. National Clinical Audit of Psychosis: report published 14/07/22 - Response provided

List of delayed & outstanding Part A returns

National Audit publication	Reason for non-response & escalation
National Diabetes Inpatient Safety Audit (NDISA) – 2018-21 report – publication 2 Aug 22	Escalated to Clinical directors, BCUHB Diabetic lead and Head of CE. Meeting with BCUHB Diabetic lead held 9th November 2022 to discuss outstanding response. Lead agreed to support progress with outstanding diabetic responses, focussing on National Core Diabetes Audit (no response to the most recent two reports).
National Core Diabetes Audit – Report 1 2020/21 – publication 14 Jul 22	Escalated to Area Medical Directors, Clinical directors, BCUHB Diabetic lead & Head of CE. Meeting with BCUHB Diabetic lead held 9th November to discuss outstanding response. Lead agreed to support progress with outstanding diabetic responses, focussing on National Core Diabetes Audit (no response to previous two reports).
National Diabetes Audit: Type 1 Diabetes – 2020/21 report – publication 16 Jun 22	Lack of engagement from East and West to requests for a response to the publication escalated to Area Medical and Nursing directors, BCUHB Diabetic lead and Head of CE. Meeting with BCUHB Diabetic lead held 9th November 2022 to discuss outstanding response. Lead agreed to support progress with outstanding diabetic responses, focussing on National Core Diabetes Audit (no response to previous two reports).
National Diabetes Audit - Adolescent and Young Audit (AYA) – 2017-21 Type 1 report – publication 16 Jun 22	Lack of engagement to requests for a response to the publication escalated to Area Medical directors, BCUHB Diabetic lead & Head of CE. Some issues highlighted regarding ownership of this report (Paediatric or Adult services) Meeting with BCUHB Diabetic lead held 9th November 2022 to discuss outstanding response. Lead agreed to support progress with outstanding diabetic responses, focussing on National Core Diabetes Audit (no response to previous two reports).
NACAP: Adult Asthma & COPD - 2021 Organisational Audit Report – publication 16 Jun 22	Central respiratory team currently feel they are not in a position to submit an action plan as the lack of progress against many of the requirements is stark, this has been raised at the Central CEG. Part A received from East & West

The National Clinical Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) – Main report 2022 – 14 Jul 22	Poor engagement with data submission has been reported regularly to CEGs on all three sites for two years. Audit leads report lack of resource. Non-submission of part A has been escalated in line with SOP, reported to Head of Clinical Effectiveness, Clinical Effectiveness Groups and discussed with Interim Operations Manager Childrens Services

2.1.2 Part B returns

Two of the three part B returns due were received, see table below. The Part B response for the National Diabetic Foot Care Audit (NDFA) is outstanding. The Audit lead reports this is due to high level of sickness in the department and clinical pressures.

Audit	Lessons/actions
National Paediatric Diabetes Audit	**West** – improve foot examination/completion rate, psychological screening, and dietetic educational sessions as part of additional dietetic contact. **Central** – improve proportion of patients having HbA1c checks, reduce high HbA1C levels and improve retinopathy screening **East** - improve proportion of patients having HbA1c checks, reduce high HbA1C levels and improve retinopathy screening
National Audit of Breast Cancer in Older Patients	Use of Frailty score tool in clinical setting; outcomes to be added to recorded dataset and record recurrence and endocrine therapy information when new Wales Cancer Information System allows.

2.2 Benchmarking

When a National Audit report includes Health Board specific data we benchmark BCU against National outcomes and against BCU data in previous reports Nine National Audit reports have been published in Quarter 2. Five of these included BCU identifiable data.

The table below outlines the benchmarking information. Of note while National Core Diabetes (Report 1 Care processes & Treatment Targets) maintains a green RAG rating against national standards it is noted that we have performed less well than in previous reports.

Key	***Comparison to National Benchmark*:**	***Comparison to Last BCUHB Report*:**
R	Where BCUHB reported performance is at or above the benchmark in less than 50% of KPIs	Where the previously reported BCUHB performance has deteriorated in more than 50% of Key performance indicators according to the latest National audit report
A	Where BCUHB reported performance is at or above the benchmark in 50% to 74% of KPIs.	Where the previously reported BCUHB performance has been maintained or improved in 50% to 74% of KPIs in the latest reporting period.
G	Where BCUHB reported performance is at or above the benchmark in 75% or more of KPIs.	Where BCUHB has maintained or improved in 75% or more of KPIs since the previous reporting period

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Acute					
NCAORP/2022/01	National Joint Registry (NJR) Pub. 21 Sep 22	N/A	N/A		• This report does not provide the level of data or recommendation, which health services can measure against • Action plan is overdue and been requested
Long Term Conditions					
NCAORP/2022/07	National Diabetes Inpatient Safety Audit (NDISA) – 2018-21 report – pub. 02 Aug 22		No Comparative data available		• Action plan, was due November 2022 has been chased and will update in Quarter 3 report
NCAORP/2022/08	National Core Diabetes: - Report 1 Care Processes & Treatment Targets 20/21 – pub. 14 Jul 22	G	R	• Maintained compliance in line with national average, although performance compared to last reported period had dropped	• Action plan received January 2023
NCAORP/2022/09	National Paediatric Diabetes Audit – PREMs 2021 report – pub. 22 Sep 22	A	G	• Maintained compliance in line with national average and improved performance compared to last reported period	• Action plan due to be completed end of January 2023
NCAORP/2022/13	NACAP: Pulmonary Rehabilitation – 2021 Organisational Report publication 14 Jul 2022	Organisational report no benchmarking	Organisational report no benchmarking	• A business case has been submitted via IMTP to support Pulmonary rehabilitation	• Action plan received

Tier 1 Project reference	Title	*Performance against*		*Progress/ Completed Actions*	*Outstanding issues - by whom by when*
		National Benchmark	*Last BCU report*		
Older People					
NCAORP/2022/18	National Hip Fracture database (Falls & Fragility Fractures Audit Programme) – 2021 report publication 08 September 22	A	A	West have been consistent and performing better than national average in several key areas 1. Surgery Performed within 36 hours 2. Consultant anaesthetist and Surgeon lead Surgery 3. Physiotherapy assessment and mobilisation within 24 hours of admission and operation.	• Action plan received for YGC & YG, outstanding response for Wrexham Maelor, further update has been requested and will be updated in Quarter 3
End of Life					
NCAORP/2022/23	National Audit of Care at the End of Life (NACEL) – 2020/21 (round 3) Report – publication 14 July 22	A	A		• Action plan completed November 2022
Other					
NCAORP/2022/35	National Clinical Audit of Seizures and Epilepsies for Children and Young People – 2022 Report	Insufficient data submitted to audit	Insufficient data submitted to audit		• Part A received with Part B received
NCAORP/2022/36	National Clinical Audit of Psychosis Publication 14 July 22	R	R	• When the MHD develops EIP service this will improve compliance to enable to meet the required standards as per the National Clinical Audit Psychosis and Welsh Government.	• Mental Health Division is in the process of developing the BCUHB Early Intervention Psychosis (EIP) Service. This will mean that each of the 3 sites (previously service was only available in the West) will have their own service, hoping for all 3 sites to be up and running early 2023.

Assurance response timetable for reports published in Quarter 2 – as of 30th September 2022

Project Reference	Title of National Audit	Name of report	Date of publication	Assurance response will be within Quarter 3 Report
NCAORP/2022/35	National Clinical Audit of Seizures and Epilepsies for Children and Young People	Epilepsy 12 Main report 2022	14-Jul-22	Quarter 3
NCAORP/2022/36	National Clinical Audit of Psychosis	National report for Wales Early Intervention in Psychosis Audit	14-Jul-22	Quarter 3 – received Nov 2022
NCAORP/2022/08	National Core Diabetes Audit	Report 1 Care Processes and Treatment Targets 20/21	14-Jul-22	Quarter 3 – received Jan 2023
NCAORP/2022/23	National Audit of Care at the End of Life (NACEL)	2020/21 Annual Report (round 3)	14-Jul-22	Quarter 3 – received Nov 2022
NCAORP/2022/13	NACAP: Pulmonary Rehab	2021 organisational audit summary report	14-Jul-22	Quarter 3 – received Nov 2022
NCAORP/2022/07	National Diabetes Inpatient Safety Audit (NDISA)	2018-2021 report	02-Aug-22	Quarter 3
NCAORP/2022/18	National Hip Fracture database (Falls & Fragility Fractures Audit Programme)	Improving Understanding report on 2021	08-Sep-22	Quarter 3 - received YGC & YG Quarter 3
NCAORP/2022/01	National Joint Registry (NJR)	19th Annual Report	21-Sep-22	Quarter 3
NCAORP/2022/09	National Paediatric Diabetes Audit (NPDA)	Parent and Patient Reported Experience Measure (PREMs) 2021	22-Sep-22	Quarter 4

Key

Red	**Response overdue**
Amber	**Response not received but within deadline**
Green	**Response received**

3.0 Tier 2 Audit Program

The Tier 2 program is a suite of audits mandated across the Health Board, not reported nationally, related to high-risk activity and corporately agreed service improvement priorities. It is likely that the number of these audits will increase in line with evidence from Harms reviews, Concerns recommendations, Prevention of Future Death Notices, and Ombudsman reports. The CE team is working closely with the Quality Department to ensure we have the correct Tier 2 audit program in place to provide assurance across the risks the HB holds. There have been no Tier 2 reports delivered in Quarter 2.

Project title	Report due	Objectives
Ward Manager Weekly Audit	IRIS - continuous	This audit complements the ward accreditation framework, monitoring standards across a number of areas; patient safety, harm free care, medication safety, infection prevention, record keeping, nutrition and hydration, toileting and hygiene, patient experience, dementia care and learning disability care. The output from the audits is reported on IRIS. The metrics questions are currently under review. Ownership is locally by the ward manager and site nursing hierarchy.
End of Life DNACPR Audit	Q4	Performance is measured against standards set out in the All-Wales DNACPR policy. Improvement needs were identified and communicated within relevant Health communities. Documented compliance with Mental Capacity Act and Best Interest framework is variable and area that related QI work seeks to prioritise. The audit is continuing in all relevant areas. We have started the second audit on DNACPR forms and case notes across three sites. Data collection in Wrexham has been completed, awaiting data collection to be completed in YGC and YG. The recruitment for junior doctors to carry out data collection across three sites was challenging but this is now resolved. Otherwise, there would have been no significant problem or delay.
Audit of upper GI bleeding	Q4	National online audit being run by host HB. Objective to measure the quality of clinical management, in particular the use of blood products. - *Data collection now closed and awaiting analysis and report due Spring 2023*
Peer Review of Consent to Examination and Treatment Processes	Q4	Continuous audit reported annually. Ensure compliance with the consent to examination or treatment processes. Previous audit identified improvement required to evidence quality of patient information provided and use of EiDO information leaflets, and compliance with the Welsh Language Regulations. Data collected via AMaT.

Project title	Report due	Objectives
Health Record Keeping	Q4	Continuous audit using AMaT, which enables clinical teams to track progress locally and implement a cycle of improvement. Currently rolled out using STAR audit tool for surgical specialties. Themes linked to poor MDT records, limited evidence of discussions with patient and / or families. Roll out to all non-surgical specialties including Paediatrics, Womens and Mental Health due to commence in Quarter 3.
Antimicrobial Point Prevalence Audit (Inpatients)	Q3	Annual point prevalence undertaken under the auspices of antimicrobial pharmacists All sites completing in November, data will be sent to Public Health Wales for analysis then will produce an all-Wales report. This will then be reviewed and if needed an action plan will be developed. Data collection complete, awaiting publication of report from Public Health Wales.
Start Smart then Focus	This is continuous month by month	Continuous online audit via Public Health Wales tool, undertaken by prescribers in secondary care. Still poor compliance with audit across BCU. Agreed at BCU strategic Antimicrobial Stewardship Group (ASG) to form a short-term working group to look at audit and make recommendations to Wales AMRDB (Antimicrobial Resistance Delivery Board). The AMRDB is the group that leads the AMR agenda for Wales as the operational delivery group with all HBs in Wales. Recommendations will be made to Welsh Government on the audits to be completed around Antimicrobial Resistance (AMR) and Antimicrobial Stewardship (AMS). Piloting of a different model of data collection and feedback at Ysbyty Gwynedd is underway and this will be presented and reviewed to the working group in January, and that group will make recommendations to the AMRDB meeting in the New Year.
2222 Audit	Q4	The data collection form has been reviewed to include additional fields; some technical I.T. issues have been identified which are being addressed by Informatics. Central: pilot is running live data collection now in; West: Switchboard team will be live from of November (following familiarisation training) after which live patient data collection will commence. East: will remain unable to join the audit process as things currently stand and this is a longer-term issue
LocSSIP	Q4	Local Safety Solutions for Invasive Procedures (LocSSIPs) are short checklists to ensure appropriate patient, procedure, consent and asepsis is undertaken for all invasive procedures undertaken outside the operating theatre (or equivalent). The audit is continuous and at present is

Project title	Report due	Objectives
		purely to ensure a LocSSIP has been completed appropriately. The data is collated via AMaT, which enables continuous review of compliance, by each team.
Sepsis	Q4	As reported in The Sepsis Review for QSE: A recent publication from the Academy of Medical Royal Colleges (AoMRC) published October 2022 proposes a change in the way people with suspected severe sepsis are assessed and treated with antibiotics. The Statement proposes that NEWS2 should be used to supplement clinical judgement to risk assess the urgency of assessment and treatment. The recommendation is that patients are stratified depending on their NEWS with those with a higher score requiring an immediate response, quicker assessment and antibiotic treatment. Data shows that current compliance with Sepsis 6 bundle is deteriorating. The benefits of the AoMRC statement are 2-fold (i) the sicker patients are focused on as a priority and (ii) allows healthcare professionals more time to investigate and consider best treatment for the patient with a lower NEWS. It is estimated this stratification of risk assessment could reduce the use of broad-spectrum antibiotics by up to 75% The STEAR (Sepsis Triggers, Escalation and Antibiotic Stewardship Review) group was set up May 2022 in response to the initial AoMRC statement. It is a BCU wide group with membership from front line clinicians, AIT, microbiologists and antimicrobial pharmacists. They will oversee the transition to the new risk assessment tool for sepsis. They will work with the clinical effectiveness team and clinical staff to determine a new data set to measure compliance with the new tool. The time frame for agreement and roll out of the new risk assessment tool is anticipated for end of Quarter 4. Data collection for the new Sepsis Tier 2 audit is anticipated to commence in Q1 of 2023/24. The results of the audit will be tracked via both CEG and STEAR groups which will inform any necessary improvement and / or education needs depending on results.
Root Cause Analysis Hospital Acquired Thrombosis (RCA HAT)	Q4	NICE guideline NG89 and the All-Wales Thromboprophylaxis Policy gives clinicians clear guidance on best practice in relation to thromboprophylaxis. Following these guidelines and policies will improve patient safety and experience. RCA HAT is clinically managed by the Thrombosis Nurse Specialists on the three acute sites. An assessment tool is used, which is designed to provide assurances to the Health Board and Welsh Risk Pool in relation to the number of potentially preventable HATs as well as to gather lessons learnt. From this, the lessons learnt can be disseminated throughout the Health Board to improve practice. Data is collected from the acute sites and validated by Digital, Data and Technology (DDaT). The Thromboprophylaxis Nurses from each

Project title	Report due	Objectives
		site then carry out the RCA on all potential HATs and the resulting findings are collated by DDaT. Thromboprophylaxis used to be a Tier 1 for the Welsh Government until last year. It now sits under the Welsh Risk Pool. RCA provides learning on the risk management of HAT, which informs practice by learning from outcomes and lessons learnt as well as identifying areas that need further focus and improvement. This has resulted in further audits being carried out by the HAT team and introduction of new practices to increase patients' safety on the back of quality improvement projects. Work is ongoing with the BCUHB HAT group, DDaT and programmers to develop a HAT dashboard on IRIS to provide up-to-date, real-time feedback of RCA results and lessons learnt to HMT and governance leads.

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 Executive Director Of Nursing (Chair)
Date of meeting	20 October 2022
Version number	V1.0
Appendices	N/A

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	20 Janaury 2023
Presented by	Mandy Jones, Deputy Executive Director Of Nursing (Chair)

1. **Alert –** include all critical issues and issues for escalation

- Integrated Health Communities (IHC) updates – lack of representation/last minute nomination. Actions include refresh the representation to ensure have engagement and the right people to really focus on the listening, learning and improvements. Reporting structure within the new operating model to be confirmed to enable refresh of the TOR and IHC/MHLD/Womens's/Pan BCUHB Services reporting template to be agreed.

2. **Assurance** – include a summary of all activity of the group for assurance

- **Patient Story**: Long Covid Service Co production - The story highlights co-production working by staff and patient representatives who supported the Long-COVID clinics. Staff, stakeholders and Lived experience representatives are developing an Outcome Star PROM for long term health conditions, this new clinical tool has a real holistic focus
- **Lost Property**: Actions underway to link with IHC representatives update on areas the trials are taking place for the clear bags and yellow boxes. Discuss with Associate Directors of Nursing how this can be progressed at pace.
- **IHC Reporting**:
    - New template to be developed - focus on a positive way forward, the patient experience and what we are expecting from each integrated health community and the services. Need to refresh the lead representatives, TOR and reporting templates

to capture learning, innovation and support required to optimise patient, carer and staff experience.
  - progress in re-establishing their Patient and Carer Experience Groups, for each IHC to have met and feed into this Group.
  - Review the Terms Of Reference to ensure clarity on the remit of the group.
  - Positive initiatives around Nutrition taking place in East IHC.

- **Complaints** – Improvement of the backlog position needs to be robust and taken forward at pace, and improve communication and opportunities to help people speak out at a local level.

- **Carers update** Negative communication remains the main cause of dissatisfaction with unpaid carers expressing they are not being considered or consulted by healthcare professionals. Poor communication being the main cause of negative feedback from carers.

- **NHS Delivery Framework -** This is the last report required as not included in the delivery framework for next year and would surmise moving forward will probably be asked to provide data relating to the basic patient reported experience measures for Wales. On the whole, the Health Board is better at measuring patient's experience, and listen to what our patients are saying.

- **Item Approved:** Patient and Carer Experience Report : June-July 2022

2 Achievement – include any significant achievements and outcomes

- **IHC's:** praised the work of the PALS Team, highlighted support received and working together collaboratively and sharing information.
- **Long Covid Service Co production** -The team have been shortlisted as finalists for a partnership working award at the NHS National Awards ceremony in Cardiff taking place on the same day as the meeting.

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:	15/11/22 and 16/12/2022
Name of Chair:	Chris Lynes, Deputy Director of Nursing
Responsible Director:	Angela Wood
Summary of business discussed:	**December** was a shortened meeting due to site pressures and strike planning - discussed issues for escalation only including. • Summary of mandatory surveillance performance data including Flu, RSV and Norovirus. • Summary of learning to date on recent MRSA bacteraemia. • Key Decontamination issues. • COVID and flu vaccination rates. • New risk assessment recommending that the isolation period for patient contacts of patients with confirmed influenza is standardised to 3 days (under normal circumstances). • Mandatory training requirements for doctors. • Update on issues at Abergele hospital. • SBAR recommendations for staff testing during a COVID-19 outbreak in hospital wards and departments now in place. **November** meeting also included: • AAA reports from areas. • Learning from Corporate HCAI reviews. • New and updated IP policies and protocols. • An Infection Prevention Team staffing update. • A review of the latest database highlighting where BCUHB is seeing the highest number of blood culture contaminants. • Discussion around governance with respect to water testing. • Results of recent spot checks on commodes and mattresses. • Update on progress with Deep cleaning of bays and wards. • SBAR approved relating to requirement to perform bay to bay high level disinfection in the event of a period of increased incidence of C. difficile. • New SOP approved for Faecal microbiota transplant procedural guidance for recurrent *Clostridioides difficile* infection based on latest NICE guidance. LIPGs to identify clinical leads in East and Central. • New protocol for Identification and Management of Patients with Carbapenemase Producing Enterobacterales (CPE) approved.

Key assurances provided at this meeting:	• Further training sessions arranged for **IP Champions**. Band 5 champions in each area within Womens. • Acute sites are proactively re-establishing **Deep clean programmes** with high level disinfection e.g. HPV to try to reduce the environmental bioburden including C.difficile **Antimicrobial Stewardship:** • Despite further increases in primary care, BCU are still meeting the target for reduced antibiotic prescribing. • Paediatric guideline updated on Microguide® (collaboration across North West England and North Wales). • Long stay ARK chart pilot now underway **Estates and Facilities:** • Work underway to transition to 'MICAD Audit' as a replacement for the existing C4C Auditing tool, which will provide enhanced IPC and Domestic Services Audit oversight and reporting. • Food hygiene - all Health Board Catering facilities are scored at Level 4 and above. • Revised reporting structures have now been implemented. • Following joint working with WOD, all outstanding vacancies within the ECR TRAC process have now been fast-tracked using a Risk Assessment to allow employment to commence prior to full documentation check **Decontamination:** • There has been improved engagement with members at the Decontamination Group meeting. • The 6 monthly BCU Decontamination Self-Assessment audits are being completed as planned. • Plans have begun to centralise Endoscopy at YGC and Wrexham which will address many of the issues raised in the BCUHB Decontamination Strategy report (June 2022) but need to ensure there is a holistic view including all scopes to achieve compliance, including management of trained personnel **Safe Clean Care – Harm Free Programme** • The Celebration Event in October to review achievements and new developments was a resounding success. • As part of and International IP Week the team toured the wards to promote the new Standard Precautions policy and help staff learn more about how to use personal protective equipment safely to reduce the risk of healthcare associated infections.
Key risks including mitigating actions and milestones	• **C.difficile infection** rates have improved, however BCU still over trajectory for the year. The Task and Finish group work continues. West are to hold a 'C.diff Summit' in January. • **MRSA:** there have been 3 new cases in last 3 months – full reviews are taking place. Compliance with swabbing and decolonisation requires improvement. • ***E. coli*** rates are higher than trajectory. Causes are commonly related due to catheters. The Catheter Associated Urinary Tract Infection (CAUTI) group is to be re-visited in the new year with regard to what additional actions need to be put in place.

	• ***Klebsiella*** rates have increased; a review is being carried out to see if there are any common causes. • **Norovirus:** there have been quite a few outbreaks causing additional pressure on patient safety and flow. • **Group A Strep**: causing problems for Paediatrics, out of hours and GPs. • **Influenza:** numbers have risen considerably resulting in a number of closed beds and wards when outbreaks occur. • **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 and promoting the Bangor University IP education programme amongst non-IP staff which recommences in January 2023. • **PHW Microbiology resource Risk 1319** scoring 9; ongoing issues trying to recruit to vacant posts. This has been leading to a lack of representation at *C.difficile* ward rounds. However, a new locum consultant microbiologists started in November. • There is ongoing **poor medical engagement with Corporate HCAI reviews** – this has been escalated to the medical directors office. • **Poor vaccination uptake** to date for COVID and flu. Flu 'jab-a-thon' was poorly attended. • **Poor documentation** in relation to insertion, maintenance and removal of IV and urinary invasive devices and often no evidence in documentation that Aseptic Non Touch Technique (ANTT) is being used. • **Mandatory training for doctors:** this is not part of their contract and it is not discussed during their revalidation, so there is no assurance they are trained on ANTT. The medical representative confirmed that he has spoken to the Medical Director and they want to enforce this mandatory training as much as possible and reiterated that there should be no compromise on this and he would talk to individual Clinical Leads regarding their responsibility to have the team fit to deliver safe, effective care. **Antimicrobial Stewardship**: • Antimicrobial audits are not being completed. A short term working group has been established to review and advise AMRDB with suggested changes / improvements. • Over-prescribing of Tazocin by specific speciality of consultants; in particular this relates to the step down of Tazocin to oral medication. This was discussed at East LIPG but this is not specific to that region. • Secondary care prescribing data is still not available. • With the changes in resistance patterns, BCUHB currently use Gentamicin for gram negative infections but there are high levels of resistance and now wish to use Amikacin. However,

	unable to switch as BCU test levels in-house; all samples go to Bristol. Issue submitted to Risk Register. • Staffing issues in Antimicrobial Pharmacist team; a lot of team on secondments with no replacements. No Pharmacist currently dedicated to Primary Care. • 4C prescribing in Primary Care - high rates in many clusters compared with rest of Wales. • All Wales trajectory for Primary Care prescribing is above trajectory for the first time in 5 years. In BCU prescribing has increased although we are still on trajectory at present. • Poor attendance from Primary Care at Antimicrobial steering group meeting **Decontamination:** • Decontamination Risk 4325 'Potential that medical devices are not decontaminated effectively so patients may be harmed', scoring 16 unchanged. Action plan in progress. Agency Decontamination Consultant started with BCU in November and is developing a Decontamination strategy. • Significant Mechanical issues (Steam Generator) at SSD YGC resulted in surgical instruments being transferred over to WMH SSD for reprocessing for several days in early November. Concerns raised regarding the sustainability of this contingency plan as WM SSD also in poor condition. • Tracking and traceability system in all three SSDs will be out of support on 31 December 2022. If it fails and they have to revert to a manual system, there will be delays in turnaround times and increase in staffing costs. Also, in the event of a look-back exercise, difficulty in identifying the equipment used in a procedure. New system unlikely to be in place until at least March 2023. • ENT Nasendoscopes decontamination standards vary across BCU sites with a mixture of the Tristel 3 stage wipe system and automated process, supplemented by disposable Nasendoscopes. Advice on decontamination process is being identified as a reason for delay in patient treatment in WM, alternative process and risk assessment being taken to Clinical Effectiveness Group for approval by Clinical Lead **Estates and Facilities issues**: • Domestic Services had received additional monies to support the Covid-19 addendum. This funding may now be removed which will result in a reduced Domestic service i.e. returning to original standards pre-Covid. This is a major concern as E&F will be losing £2.5 million worth of cleaning across BCUHB per year. High standards with regards to environmental cleanliness and cleaning will have to be removed if no longer funded. The money was originally agreed on a reoccurring basis. • The budget for SCC and Decontamination Infrastructure upgrade has been reduced from £1M to £500k following a review and approval at the Capital Investment Group.

	• Risks associated with Abergele Hospital site in terms of infrastructure, fabric and failures and roof leaks have been escalated. £50K has been secured from Operational Estates Discretionary Capital and £100K from BCU Discretionary to implement a number of improvements around the roofing fabrics and infrastructure. Discussions have taken place with Central Operations Director around creating a Business Continuity Plan for Abergele Hospital. **Safe Clean Care – Harm Free Programme** – meetings suspended from 7/12/22 – 11/01/23 due to operational pressures.
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	• A summary from IPSG is also sent to PSQ.
Matters requiring escalation to the Board:	• Nil
Well-being of Future Generations Act Sustainable Development Principle	• Shared Services Partnership support BCU with assessment of risks and to identify 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 forensics. • IP are supporting the agenda to reduce waste and environmental impact.
Planned business for the next meeting:	Range of regular reports plus: • Update on Sleep Angel mattresses • BCU-wide SOP related to curtain changes. • Presentation on linked C.difficile cases in West. • New SOP related to management of Water Outlets. • Update on National Standards for Cleaning.
Date of next meeting:	23 January 2023

Chair's Report
Alert Assurance Achievement (AAA)

Reporting Group	
Name of meeting	Patient Safety & Quality Group
Chair of meeting	Mandy Jones, Deputy Executive of Nursing & Midwifery
Date of meeting	14th November 2022
Version number	1.0
Appendices	None

Reporting To	
Name of meeting	Quality, Safety and Experience Committee
Date of meeting	20 Janaury 2023
Presented by	Mrs Angela Wood, Executive Director of Nursing and Midwifery

1. Alert – include all critical issues and issues for escalation

SMSG (Safer Medication Steering Group)

Pharmacy and Medicines Management (PMM) have received several reports of clinical areas not being able to obtain supplies of syringes to administer medicines. Difficulties in obtaining both oral syringes and insulin syringes have been escalated to senior nurses and the procurement team. Paediatrics and neonatal areas have informed PMM of difficulties with supplies of oral syringes for liquid medicine administration. This seems to be a particular issue for West clinical in-patient areas.

PSQG members were asked to remind nursing staff that issues with any syringe availability must be escalated to both nursing management and procurement teams.

IPSG

There has been an Increase in C difficile in West and Central, inconsistent and/or no medical representation at PIR's. E coli and MSSA rates have increased. In comparison with other Welsh Health Boards, we are 4th for C-Diff, 3rd for MRSA, 4th for MSSA, 4th for E-Coli, 2nd for Klebsiella and 2nd for P. Aeruginosa.

HPV cleaning – Integrated Health Communities (IHC), MHLD and Womens services were asked for an update to be added within the December Triple AAA reports regarding compliance.

Cancer Services

There are a number of consultants who have now left the oncology service within BCUHB. Support is being provided by the executives. Two consultants have given their expression of interest.

Currently there are gaps in the administration and radiotherapy planning teams – recruitment is being discussed and mitigation being considered.

Womens Services

Welsh Ambulance Service are continuing with the suspension of the home birth service. Escalated to WG as a sensitive issue.

YG / West Area

Medical Staffing fragility within medical acute wards-Aran and Dulas, placing significant pressure on specialty teams due to the high number of outliers. Discussions are ongoing via a weekly SDEC / Gogarth Meeting – it is now intended that there will be an SDEC, frailty and short stay combination (assessment floor) model to be on the Aran / Gogarth footprint. Plans to move SDEC have been delayed as a result of pressures, but this is now planned for mid - November, following a MADE event where it is hoped that pressures on the Acute site will be reduced.

YGC / Central Area

Carer support provided from the Community Resource Team (CRT) to prevent Package of Care (POC) breakdown or to facilitate discharges, now requires registering with CSIW. In total, this affects about 3035 staff being a greater issue in East area. A responsible individual registered manager will need to be identified within BCUHB. There are implications for the staffing in that all the staff will have to be registered with social care Wales. All staff are required to be trained to level two or three NVQ and there is an annual fee, so a cost implication for BCUHB. Further work is planned to address this across BCUHB

WMH / East Area

Ambulance delays held outside the ED (Updated October 22) - Ongoing delays in timely ambulance handover and an increase in the length of delays outside of the ED, increase seen in length of time for patients remaining in ambulances. Ongoing support and daily plans required from site in response whilst holding WAST/WMAS crews. Additional clinical assessment areas being considered by converting decontamination storeroom to a second RAT/IR room for Ambulance patients (temporary room made available in interim).

INCHS

Allergen incident occurred in November 2021. Following approval of the Managing theraputic diets SOP in the September PSQG chair of the Artificial Nutrition Group will progress with BCUHB wide launch.

Inpatient falls

The Strategic Inpatient Falls group are unable to provide the assurance that the bedside learning model is currently being implemented with pace. There is a risk that the Health Board will not meet the expectations of the HSE in terms of risk assessment and interventions for every Adult Inpatient, should a revisit by HSE take place. Falls risk has been tabled for RMG January 2023. Flat lifting equipment – A task and finish group has been set up to progress purchase.

YGC/Central Area

Safeguarding risk due to impact on capacity of health visitor teams to manage high number of requests for MARAC reports in Central Area (Conwy in particular). Matter raised with Safeguarding team – meeting convened on the 13th October to discuss further. There is ongoing liaison with the safeguarding team in relation to MARAC requests.

There are continuing Concerns regarding the lack of a clear plan to support the frailty unit – leading to lack of governance and increase risk of incidents. A review of current staffing and skill mix will take place. Consideration of relocation of the unit to provide an improved working environment will also be discussed.

Risks in IHC: One new live risk, transport of neonatal patients for eye screening from YG to YGC. Risk of delays with ambulance transfer back to YG would increase acuity in YGC neonatal unit. Risks submitted and discussed in monthly risk register meeting (acute) for approval and Area Q&S meetings

Reported that there is no dedicated deep clean team for the central IHC posting a risk to the HPV programme

2. **Assurance** – include a summary of all activity of the group for assurance

Womens Services

Safety Issue with Wireless Cardiotocograph (CTG) monitoring: A safety issue had been identified with the use of wireless CTG monitoring. The investigation into the underlying issues is being progressed. EBME has confirmed that the Philips CTG machines in operation locally are not affected by any of the issues raised in this document. The user manual states: “Using a mixture of wired and cable less fetal transducers is not supported. You can use either wired or cable less fetal transducers”. As a result, any of the Phillips CTG’s fitted with a wireless base station when connected to one of the 4 red fetal sensor sockets will only allow measurements from the wireless transducers even if a wired transducer was to be plugged in. Vice versa if a wireless station is not fitted, the CTG can only work with a wired transducer.

East Kent Report reviewed and key areas of concern included team work, compassion and listening. Recommendations considered and taken forward by the womens service leadership team.

SMG

Controlled drugs webinar held in September 2022 and offered to independent providers. Good feedback received. Planned webinars for November – care practitioners and governance arrangements around administering medications in the care home setting.

3. Achievement – include any significant achievements and outcomes

YG / West Area

Part of a Bevan commission trial for the introduction of colon capsule usage in Wales as an alternative, in certain circumstances, to a colonoscopy procedure. Dr Sutton, Consultant Gastroenterologist has completed all training aligned to this additional programme of work therefore service will continue with instigating the new service trial. The first patient will be undergoing the procedure on 12.09.22

Sioned Thomas- Health Centre manager for Hwb Iechyd Eifionydd has been nominated for Betsi Award for leadership.

YGC / Central Area

District Nurse Kelly Clewett awarded for her dedication to her team named Chwarae Teg Women Inspire Women in Health and Social Care Champion at a ceremony in Cardiff, on September 30. Kelly received her award from BCUHB Executive Director of Nursing Angela Wood.

Neonates held a Readathon 5th-16th September where the importance of reading books was promoted, singing and talking to babies. The event was part of the Little Readers Read-A-Thon an international event run by NIDCAP Centre. NIDCAP stands for the New-born Individualised Developmental Care and Assessment Programme. Books were donated by Book Trust Cymru, Book Start Denbighshire and from a parent whose baby had been on the unit previously.

WMH / East Area

A Dietitian based at HMP Berwyn won the Clinical Nutrition Professional of the Year award.

Heart Failure Expert Patient Programme - First cohort of patients currently attending the programme. The Heart Failure team are hoping to present poster at National Conference in London in November

Launch of PG Cert Emergency Nurse Course at Glyndwr - Following development between the senior nursing team in Wrexham ED and Glyndwr University the first cohort commenced in September 2022 – BCUHB and SaTH ED nurses

Womens

North Wales chief midwifery officer been appointed and positive feedback given following her visit to the Health Board.

There has been an appointed maternity and neonatal champion

SMG

QiC Diabetes Excellence Awards. The medicines management nurse West and Medicines Safety Team Leader along with the West Diabetic specialist nurses were finalists at the Sanofi excellence award ceremony, held on Thursday 13th October. The team attended for the work undertaken for insulin safety week

Diweddariad glendid amgylcheddol 20/01/2023

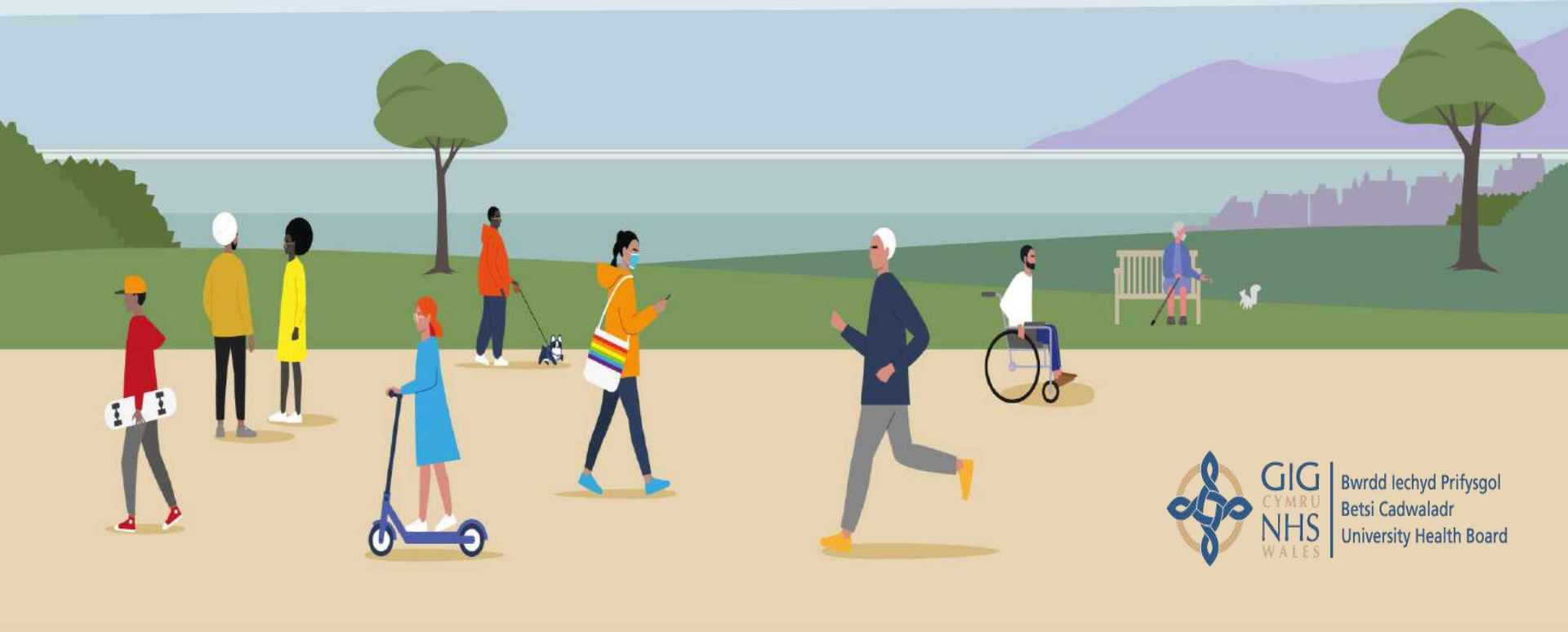
Rebecca Gerrard
Cyfarwyddwr Atal a Dadlygru Heintiau

Rod Taylor
Cyfarwyddwr Ystadau

Environmental Cleanliness Update 20/01/2023

Rebecca Gerrard
Director of Nursing Infection Prevention and Decontamination

Rod Taylor
Director of Estates



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Environmental Cleanliness Update

- "The Power of Three"
  - Nursing
  - Domestic Services
  - Operational Estates
- National Cleaning Standards for Wales
- Environmental Cleanliness – Domestic Services
- Credits 4 Cleaning Auditing
- Environmental Cleanliness Innovation
- Safe Clean Care Harm Free Programme – Capital investment
- Estates, Infection Prevention Improvements
- Measures of Success

"The Power of Three"

The cleanliness of any hospital environment is important for infection prevention and patient well-being. 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 2009 set out the cleanliness requirements for all Health Boards in Wales.




National Cleaning Standards for Wales

- The National Standards of Cleaning 2009 set out the cleanliness requirements for all Health Boards in Wales.
- Following the recent publication of the new English Cleaning Standards, Wales will be reviewing the welsh standards with the review recommendations being published in March 2023.
- The Health Board have Nursing & Facilities representation on the review Group.
- An internal T&F Group has been established to support the review.

Domestic Services

- All cleaning services are provided by the BCUHB Estates & Facilities Service as a managed in-house service.
- The service is allocated a revenue budget on an annual basis. For the 2021/22 financial year, the overall budget for the service was £16,162,903
- Additional Revenue was provided in quarter 4 of the 21/22 financial year to support the purchase of additional cleaning equipment for use across the organisation - £150K
- Covid 19 Cleaning Addendum - A financial request was approved by the Health Board in July 2021 to support the implementation of the guidance. The bid equated to £2.7 million, 2.5m pay & 0.2m Non-pay.
- A programme of recruitment commenced in September 2021 to recruit Domestic Assistant posts to meet the requirement of the guidance;-
  - 3 x Domestic Supervisors
  - 96 x Domestic Assistants
  - 6 x Deep Clean Operatives (Vent Cleaning)
- The additional revenue funding will form part of the Facilities budget for 2022/23 on a recurrent basis.

Establishment

A large focus has been placed on the recruitment of new Domestic Assistants over the last 12 months supported by workforce & recruitment colleagues.

This has required different methods to be used outside the normal recruitment process to attract candidates who wouldn't normally apply due to the NHS jobs application criteria.

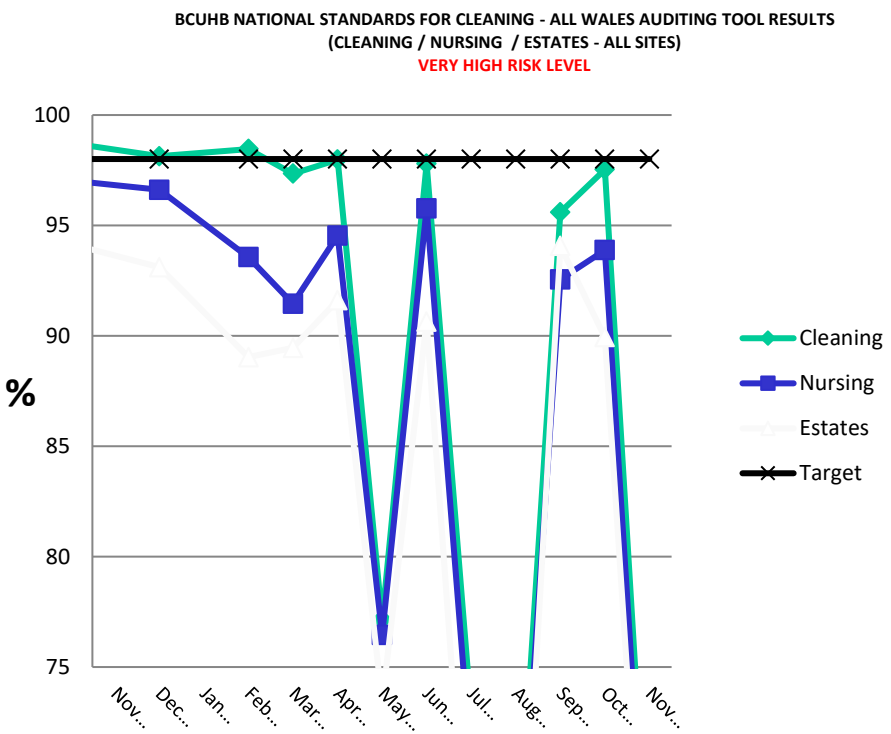
From the 1st August 2022 the 3 Operational Facilities Teams have realigned to the Integrated Health Community Management Model.

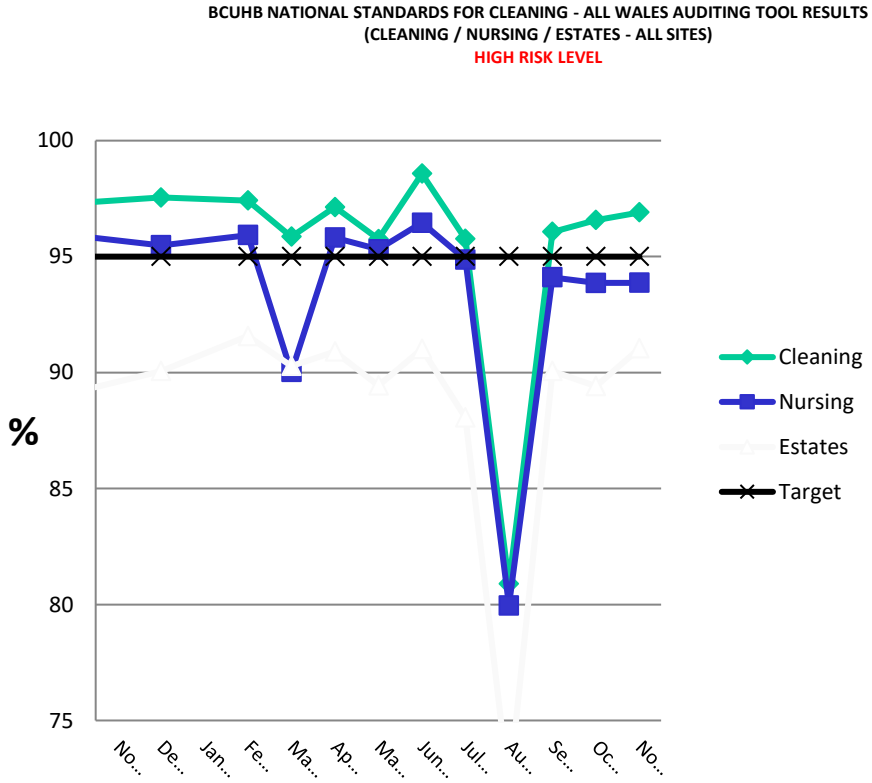
Band	Title	Establishment							
		Pan-BCU		Centre		East		West	
		Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
5	Assistant Hotel Services Manager (Domestics)	3.00	3.00	1.00	1.00	1.00	1.00	1.00	1.00
3	Domestic Supervisor (BAU)	26.31	27.15	11.53	11.53	6.66	5.97	8.12	9.65
	Domestic Supervisor (C-19 Addendum)	3.00	2.80	1.00	2.00	1.00	0.80	1.00	0.00
2	Domestic Assistant (BAU)	492.56	495.24	191.03	182.89	163.77	161.08	137.76	151.27
	Domestic Assistant (C-19 Addendum)	96.00	51.89	32.00	16.34	32.00	12.28	32.00	23.27

Credits 4 Cleaning

- Monitoring continues to be undertaken in accordance with the National Standards for Cleanliness in Wales (2009), using the Credit 4 Cleaning Audit Tool. The Domestic Supervisors facilitate the audit process with support from nursing & estates colleagues.
- All HMTs, Senior Nursing, Ward Matrons and / or Departmental Heads are e-mailed a list of the cleaning results at the time of audit for their own areas and on a monthly basis.
- 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, and is due to be replaced by MICAD in 2023.

Credits 4 Cleaning BCUHB





Which Clean do I Mean?

- **The *"Which Clean Do I Mean"* document provides:**
  - The Infection Prevention (IP) recommendations to address a growing agenda that requires an optimised focus around cleaning to mitigate risk
  - A description of the different types of cleans required:
    - Terminal (discharge) Clean
    - Enhanced Clean
    - Reactive Full Ward Deep Clean
    - Proactive Full Ward Deep Clean
  - Clear IP direction relating to the cleaning/disinfection processes and products / technology to be used for specific infections (e.g. C.diff, COVID, Group A Strep.) and different situations (e.g. Outbreak, Period of Increased Incidence)
  - Clarity around responsibily related to the Cleaning Responsibilities Framework

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Which Clean do I Mean?

	No known infection	Known infection e.g. MRSA, ESBL, VRE, TB, Grp A strep , Flu, COVID, Shingles, Paediatric infections	Bay following confirmed C.diff OR presumptive/confirmed MDRO (e.g. CPE) *Patient is likely to have already transferred to a side room*	Diarrhoea in Sideroom OR OR presumptive/confirmed MDRO (e.g. CPE)	PII/Outbreak declared
1	Discard all waste/disposables and empty bins Remove all bed linen		Discard all waste/disposables and empty bins within the bay Remove **all** bed linen	Discard all waste/disposables and empty bins Remove all bed linen	Remove all waste and empty bins throughout the ward
2	Check curtains around the bed space. If visibly soiled remove.	Remove curtains in side room or around the bed space within the bay	Remove **all** curtains throughout the bay	Remove any curtains within the room	Remove **all** curtains throughout the ward
3	Disinfect **side room** (incl. ensuite) or **bed space within a bay** and any equipment used by the patient as per SOP using approved disinfectant	Disinfect **side room** (incl. ensuite) or **bed space within a bay** and any equipment used by the affected patient as per SOP using approved disinfectant	Disinfect **entire** bay and any equipment within the bay per SOP using approved disinfectant. Disinfect communal areas used by the symptomatic patient (e.g. toilet/shower room)	Disinfect **side room (incl. en-suite)** and any equipment used by the patient as per SOP using approved disinfectant	Disinfect **entire** ward and all equipment as per SOP using approved disinfectant.
4			For C.diff and if achievable - list ward for bay by bay deep clean (using **HLD** as part of deep clean programme)	Leaving all cleaned equipment in side room, **HLD** of the room and ensuite should be performed. If achievable - list ward for bay by bay deep clean (using HLD)	If patient was isolated place as much equipment as possible in vacated room and **HLD of room and en- suite**
5	Replace curtains if necessary	Replace curtains	Replace curtains	Replace curtains	Replace all curtains
6		Disinfect associated toilet/shower rooms using approved disinfectant	Clean and **HLD** of any associated toilets/shower/ bathrooms		
7			If patient used a commode and/or was incontinent HPV sluice (overnight) as part of terminal clean		

Note: When disinfecting using Hypochlorous acid, HPV or UVC (this as a last resort), place as much equipment as possible in the area being decontaminated

Single beds must not be closed due to the unavailability of Hypochlorous Solution/HPV/UVC. An actichlor clean should be performed in this instance unless stated otherwise by the IPT. In an outbreak situation, discuss with the IPT

High Level Disinfection – Deep Cleaning Programme

Aim: to achieve an uninterrupted rolling programme of High Level Disinfection (HLD) using Hypochlorous Acid (HA) or Hydrogen Peroxide Vaporisation (HPV).

- Both highly effective in removing C.diff spores from the environment – not achieved as effectively using routine disinfection products or Ultra Violet light technology.
- Need proactive and a reactive programme of HLD.

- A full ward decant of patients and specialist equipment is the most effective method, leaving all standard and beds behind on the ward to be cleaned.
- Where full ward cannot be achieved, bay to bay HLD is an option, however this is less effective because:
  - this will not include the main corridor and around the nurses station
  - it is difficult to HLD the toilets/communal areas/sluice etc. on a functioning ward
  - footfall and the movement of patients reduces the effectiveness of the HLD

- The COVID pandemic allowed many wards to receive a bay to bay HLD – post outbreak/in preparation for re-opening, however these did not always target areas identified as having bio-burden of C.diff.
- YGC and YG made good progress before Christmas – particularly targeting C.diff areas.
- Winter respiratory viruses and strikes have slowed recent progress.

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High Level Disinfection
Full ward deep cleaning progress

	East	Central	West
July	Fleming	Ablett Dinas (male) DOSA Menlii – UVC only	HDU Gogarth – UVC only Ogwen – UVC only Conwy – UVC only
August	Mason SAU	Ward 1 Llewelyn – UVC only	Dulas Tudno
Sept	ACU, ITU, POW, U5, Ceiriog, ENT, AMU, Erddig	Ward 12 Morfa – UV only Aberconwy - UV only	Tryfan Enlii Morfa – Altwen
October	Erddig Fynnon A Fynnon B	Ward 12 Ablett (Dinas) Ward 8 Morfa – UV only Aberconwy - UV only Llewelyn – UV only	Prysor Ffrancon Tegid
November	None performed	AMU Ward 2 CBH UVC only Ward 3 Ward 10 Ward 14 UVC	Tegid Aran Conwy Hebog Alaw
December	None	Ward 3 Menlii Ward1 Renal UVC/HA Waed 4 Ward 8	Francon

Monitoring and Assurance

Variety of methods used:

- C4C (includes nurse, domestic cleaning and estates)
- Ward sisters and Matrons audits (IRIS)
- Full Infection Prevention audits
- Spot checks
- Commode audits (IRIS)
- Mattress audits (IRIS)
- Adenosine triphosphate (ATP) – quality check
- “I am clean” stickers / indicator tape
- Cleaning checklists – being reviewed to ensure standardisation
- Cleaning Responsibilities Framework

MICAD Audit Programme

- Transition to MICAD Audit as a replacement for the existing C4C Auditing tool
- Benefits: Enhance IPC and Domestic Services Audit oversight and reporting
- Current status: Trial platform in use, update of floorplans in progress, to allow transition to new system in 2023
- Reporting to IPSG

Staffordshire University Partnership

- Investigate the application of fluorescence in the measurement of cleaning efficacy in healthcare settings.
- Output to include a subjective estimate of the presence of fluorescence, and the estimated surface area that is suitable for analysis, using filtered light analysis
- 'Forensic Search' undertaken 24th & 25th October 2022, at Ceiriog ward, Chirk Community Hospital
- Successful funding application to Healthcare Infection Society (£10k) to enable purchase of equipment and employ a research associate for the project
- Signing of MoU undertaken at SCC-HF Celebration Event 26th October
- Celebration event at Staffordshire University 8th December
- Next steps being agreed by Project Group

ATP Testing

- A quantitative process for measuring the cleaning process on any surface
- Pilots completed with Housekeeping Supervisors, 315 readings recorded
- Working with Infection Prevention to roll out next phase of testing
- Swab locations for IPC pilot agreed, and programmed into units and cloud-based portal.
- Handheld units in place with each IPC team across the three areas.
- Review of pilot results due end of December with support provided by E&F for analysis and reporting of results.

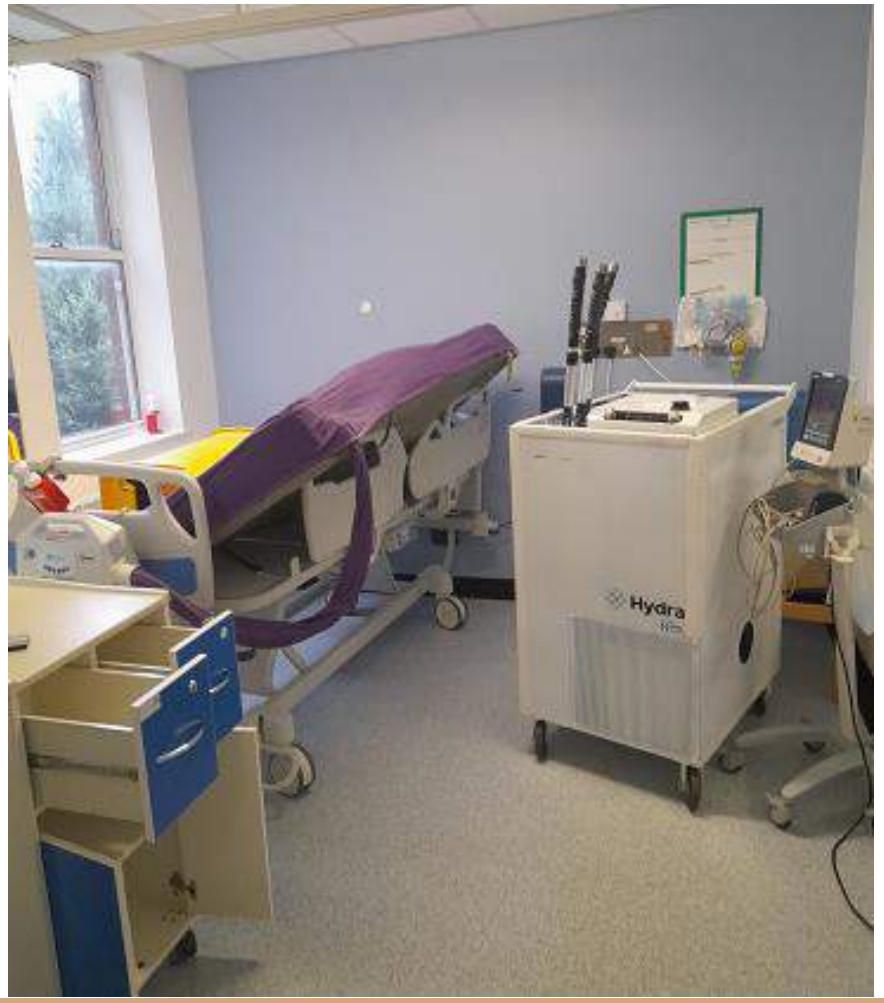
- Further info - https://youtu.be/tsjLPP6y1Ok

Hypochlorous Acid misting

- Fast and safe alternative to Hydrogen Peroxide (HPV) for whole room misting disinfection
- Testing locations – nMABS clinics at Alltwen, LLGH and WMH
- Capital purchase of units and consumables
- Training & SoPs completed
- Rollout complete
- SBAR written to support additional equipment purchase for community sites

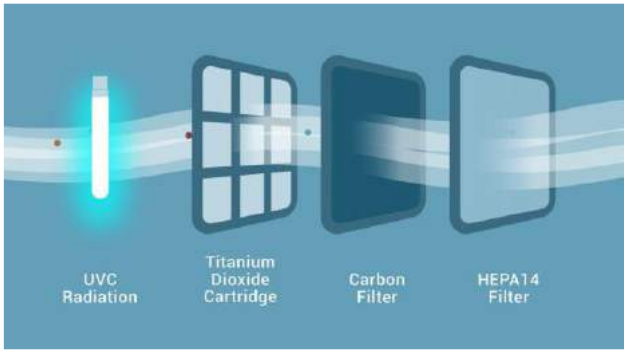
High Level Disinfection of a single room using Hypochlorous Acid machine

Note - there are still areas across the Health Board where HLD cannot be achieved due to lack of bay doors, ceiling voids, ventilation issues etc



Air Purification Units trial

- Pilot to measure efficiency and efficacy of units, plus staff feedback
- Pilot location for initial staff & patient feedback completed on Hebog Ward, YG
- Further feedback being gathered at additional locations – ED waiting room (YG) and POAC consultation rooms (YG).
- Unit capacity set to achieve Air Change compliance as per HTM301
- 4 x Units at Ysbyty Gwynedd for first phase of testing - feedback from staff and patients
- Testing Strategy agreed for second phase of testing – Active Air Sampling & Air Particulate testing to determine efficacy of units
- Testing of units undertaken on the 12th and 13th December on Hebog Ward
- Reporting to Ventilation Safety Group
- Further info - https://youtu.be/ou6Yj_OoIIs

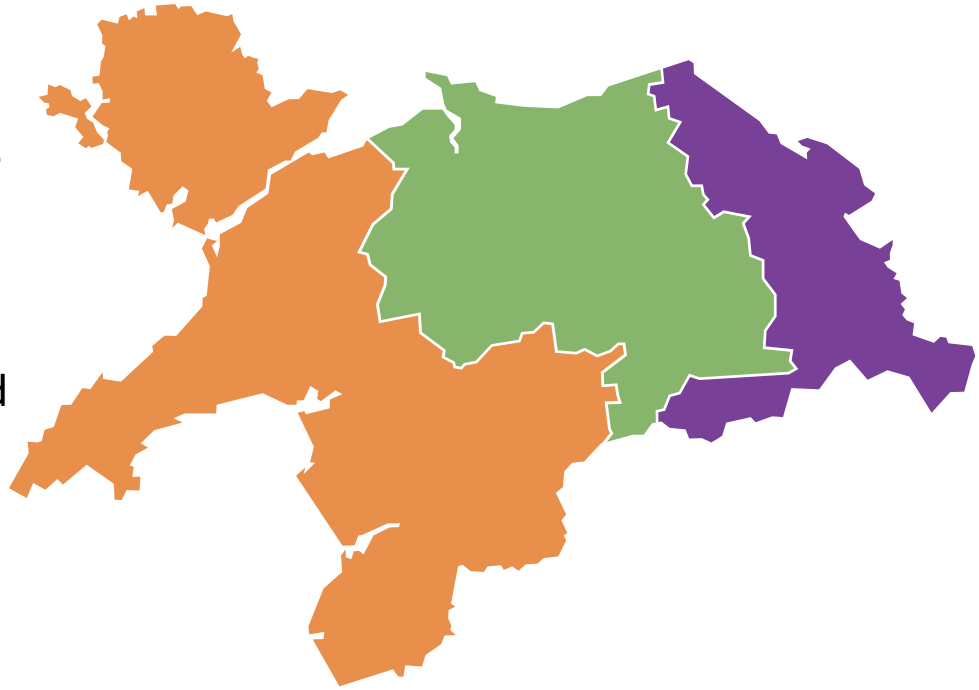


Estates Strategy

BCUHB currently has one of the largest property portfolios in Wales; services are delivered from c. 238 properties (a total of c. 420,000 m2) with a value of £569m[1] and an annual running cost of £73m[2] in 21/22.

Existing Estate Profile and Localities

Our services are delivered from, and our staff are based at a total of 238 properties (including GP owned, third party developer and private landlord primary care premises). The accommodation also hosts staff and services from other organisations including local authority and third sector.



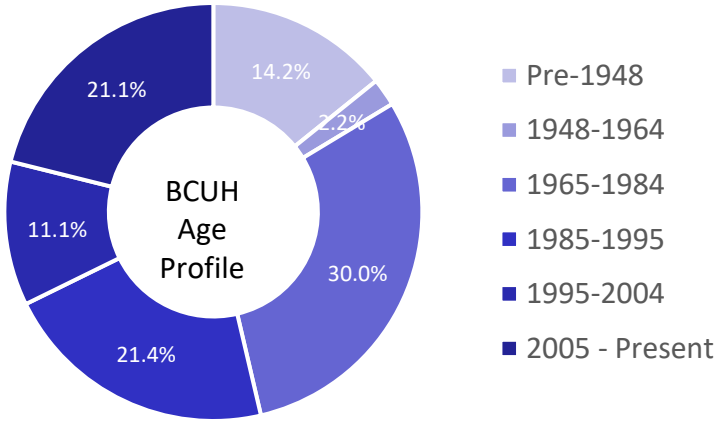
[1]Total freehold buildings, external works and land value as of 31/3/22; [2]Estates and facilities pay and non-pay costs

Estate Age

Our estate comprises a range of property types, from acute hospitals to primary care facilities. Circa 45% of the estate is greater than 40 years old, compared to a Wales average of 49%. The majority of estate, by total Gross Internal Area (GIA) m^2, is freehold.

Existing Estate Age Profile

The age range of our estate, which varies widely from the 1813 Denbigh Infirmary to the Holywell Community Hospital, is summarised below.



Environmental Management Group Priorities 2022-23

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 - £130K
- East Acute and Area - £130K
- West Area - £130K
- MHLD - £60K

The process to approve all projects will be as detailed below:

Estates and Facilities to develop a project brief based on priority risks determined by the Local Infection Prevention Groups and C4C Audits, this will be carried out in partnership with Infection Prevention and Clinical Leads / Service User. (Acute, Community and MHLD)

Estates and Facilities to prepare a project plan (Inc. Costings) which will be presented at the Local Infection Prevention Groups for discussions and approval with oversight from the Estates Environmental Group and funding approval by the Capital Investment Group.

Project Plan will be implemented and a progress report will be presented at each Local Infection Prevention Group Meeting and meeting of the Estates Environmental Group.

Discretionary Capital Funding programme : Key Themes

LIPG West	LIPG Centre	LIPG East	LIPG MHLD
• Upgrade bathroom to shower room • Upgrade of Clinical WHB to include sensor taps • Upgrade of Flooring	• Upgrade of Flooring • Upgrade of bedrooms including decoration • Upgrade of Kitchens • Installation of Clinical WHB • Replacement of doors • Handrail Replacement	• Upgrade of Theatre Support Rooms • Installation of Clinical WHB • Upgrade of storage facility at ward level • Upgrade of clean utility rooms	• Upgrade of Flooring • Upgrade of Treatment Room • Upgrade of Building Fabric
£130k	**£130k**	**£130k**	**£60k**

Estates Environmental Improvements

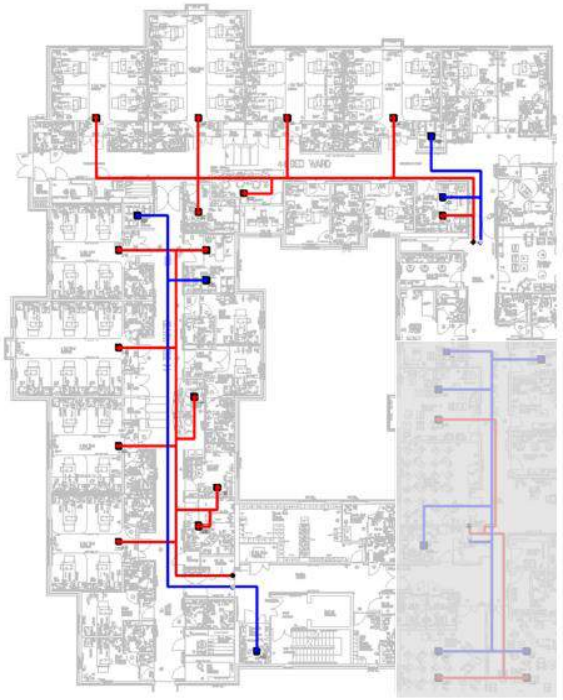
Environmental Improvements

- Installation of 16 x Bay doors at Ysbyty Gwynedd
- Bay doors at Llandudno GH
- Wash Hand Basins at 36 locations in Wrexham Maelor
- Flooring replacement at Colwyn Bay Hospital
- Specification for Works at Glan Clwyd ED
- Floor markings at Ysbyty Gwynedd
- Quarterly ‘Clear the Clutter’ Campaigns

Estates Environmental Improvements

Ventilation

- Ventilation reviews completed for acute and community sites
- Ventilation data consolidated into one spreadsheet.
- Data shared with Heads of Nursing and IP
- Ward Environmental Risk Assessments now include Ventilation in its scope



Clear the Clutter Campaign 2022-23

- Campaigns arranged for
- July 2022 (Completed)
- October 2022 (Completed)
- January 2023

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Measures of Success and SMART Objectives

Work Stream	Project	SMART aim	Current Status	Measure of success
Clean Ward-Hospital	Update COVID Addendum to the Cleaning Framework	Complete review of Process guides (SOPs) for both Domestic and Nursing activities.	Review Complete. SOPs 50% updated.	100% of SOPs complete by end of 3rd 90 day period
	Develop BC for a Discharge Cleaning Team		On hold – Fully Implement Covid Addendum (both Pay & Non-Pay) and then undertake a review of nursing and domestic cleaning tasks in line with CRF	Business Case submission
	Recruitment of COVID19 Addendum Cleaning Staff	Secure Funding and Recruit 96 WTE staff	Funding Secured, 50 Staff Offered positions. Part of Area Teams BAU	Recruiting ongoing to fill remaining posts.
	Reinforcement of C4C Auditing	Conduct ATP Trial at 3 sites to formalise procedures of application in the workplace	1st Trial Complete. Lessons taken forward, 2nd and 3rd trials scheduled for 3rd 90 day period.	All trials complete and revised Best Practice incorporated into SOPs by end of 3rd 90 day period
	Conduct Ventilation reviews – Non Critical areas	Appoint Authorising Engineer for Ventilation Authorising Engineer conduct Reviews Ventilation Safety Group Provide Guidance Learning from Covid-19/Ventilation	Authorising Engineer appointed. Reviews complete. Data shared. Ward RAs now include ventilation within scope. Incorporate learning in major projects	100% Delivered
	West Area Infrastructure	Deliver Ward Segregation Improvement Project at Ysbyty Gwynedd	Works complete	100 % Complete
		Deliver Ward Segregation Improvement Project at Llandudno GH	Works complete	100 % Complete
	Central Area Infrastructure	Deliver Environmental Improvement Project for Glan Clwyd ED	Works complete	100 % Complete
		Deliver Environmental Improvement Project for Colwyn Bay flooring	Works complete	100 % Complete
	East Area Infrastructure	Deliver Wash Hand Basins Improvement Project at Wrexham Maelor	Works complete	100 % Complete
	Establish T&F Group to agree proficiencies for the Discharge Cleaning Team		On hold – Fully Implement Covid Addendum (both Pay & Non-Pay) and then undertake a review of nursing and domestic cleaning tasks in line with CRF	
	Agree scope of works that would be undertaken during a full-ward Decant - seek existing documentation re plan of essential maintenance and deep clean.		Subject to an agreed robust decant programme on each of the three sites	

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Measures of Success and SMART Objectives

SCC Work Stream	Project	SMART aim	Current Status	Measure of success
Safe Bed Space	Review of minimum bed spacing	Be compliant with National guidance	Bed spacing assessment complete	100% complete
	Ward segregation project	Be compliant with National guidance	Ogwen, Gogarth, Conwy, Alaw wards (YG) . £105k spent to date	100% complete
Safe Entry	Maintenance agreement for Sample Pods systems (pneumatic tube system)	A fully functioning and maintained Pod System at YG and WMH	Funding has been agreed for maintenance strategy. Awaiting signoff of framework to access maintenance agreement.	80% complete
Safe Break	Reconfiguration of Catering facilities to adhere to social distancing guidelines	Be compliant with National guidance	Catering facilities reconfigured in line with Covid-19 guidance at acute and community sites including MH & LD complete	100% complete
Safe Change	Increase in cleaning frequencies at changing facilities	Be compliant with National guidance	Changing facilities reconfigured in line with Covid-19 guidance at acute and community sites including MH & LD complete	100% complete
SCC-HF	Revenue Sustainability	Recurrent funding to accomplish commensurate levels of service provision that occurred under C-19 improvements	Implementation of Cleaning Standards to C-19 Addendum. Additional Catering out-of-hours provision. Completion of social distancing controls and additional accommodation Environmental Waste increases	100% Complete
SCC-HF	Capital Allocations	Secure a pipeline of funding for SCC Environmental work	Have an agreed programme of Capital Investment for 2022-23	100% Complete

Diolch

Thank you

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Teitl adroddiad: ***Report title:***	Quality & Performance Report to 30th November 2022			
Adrodd i: ***Report to:***	Quality, Safety and Experience Committee			
Dyddiad y Cyfarfod: ***Date of Meeting:***	Friday, 20 January 2023			
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 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:***	Steve Webster Interim 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 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:*** 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 EqIA yn angenrheidiol ac a gafodd ei gynnal? ***In accordance with WP7 has an EqIA 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.
Cysylltiadau â risgiau BAF: (neu gysylltiadau â'r Gofrestr Risg Gorfforaethol) ***Links to BAF risks:*** *(or links to the Corporate Risk Register)*	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:*** *None*	

Quality and Performance Report

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

Performance to 30th November 2022
Presented on 20th January 2023

Quality, Safety & Experience Committee

Table of Contents

About this Report

Welsh Government has advised Health Boards to continue to monitor performance in line with the measures included in the 2022-23 NHS Wales Performance Framework published in mid 2022. The Report is structured according to themes and the Quadruple Aims as presented in A Healthier Wales. Only those measures requested to presented to QSE Committee are included in this report.

Report Structure

This report continues to evolve 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 report, as required/requested where applicable, as quickly as possible.

The latest validated data we have access to is contained within the report. A number of mental health measures are reported one month in arrears.

All NHS measures are reported (split) and presented in separate Integrated Quality and Performance Reports (IQPR) to PFIG and QSE committees. This QSE IQPR version contains those measures relevant to QSE committee.

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 – even if some are on target (green).

Additional charts (at the end of the report) are included that provide a performance position on key activity across the Health Board that aren't covered within the main body of this report – nor is the specific focus.

DTOC graphs and narrative have been removed as nationally D2RA is the focus and is being further developed. We will update and include as required

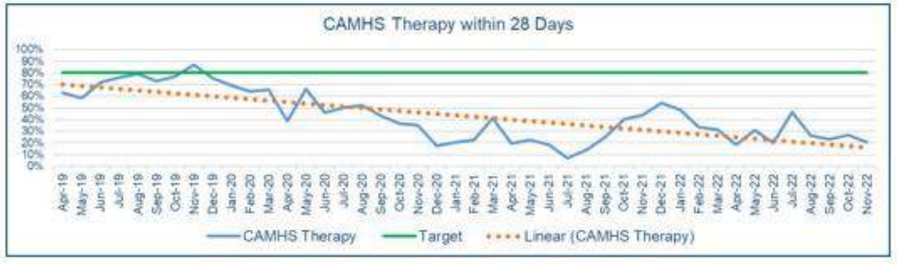
Report Development

Work is underway to utilise the full suite of MS 365, including the Power Platform to produce a digitally interactive, flexible and insightful Dashboard more reflective of modern business intelligence systems.

NB: Trend bar charts have white/light shaded areas at the top. This shading is purely a feature to allow the actual number/percentage text to be visible to the reader. Otherwise some bars would and some wouldn't (short bars) display any text. Essentially, for visual comparison ignore the white/light shading

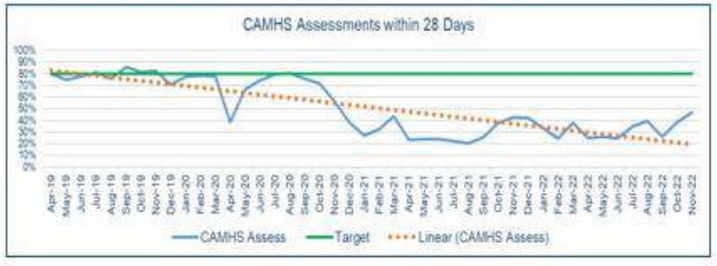
Summary Dashboard

CAMHS – Therapy within 28 Days: 20.48%



Number of New Never Events: Q2 July-Sep 2022 3

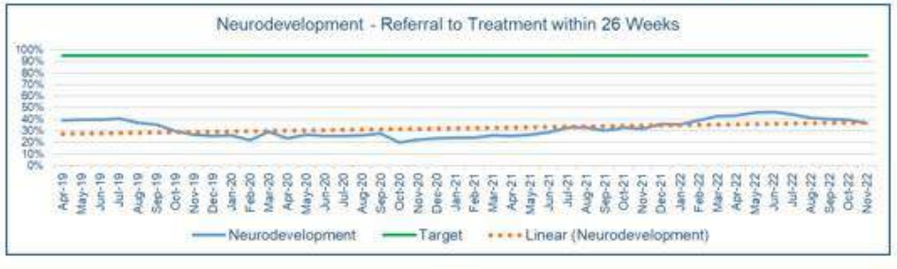
CAMHS – Assessed within 28 Days: 46.95%



Adult MH Assessed within 28 Days: 70.82%

Adult MH Therapy within 28 Days: 76.29%

Neurodevelopment within 28 Days: 36.74%



Adult Psychotherapy within 26 Weeks: 89.77%

Executive Summary

Improving Position	Static Position	Declining Position
- % of patients waiting less than 28 days for a first appointment for Specialist Child and Adolescent Mental Health Service improved for last three months, where data is available, to 100% (caution small numbers though) - % Mental Health assessments (for under 18 years) undertaken within 28 days of referral, whilst still well below target, has improved from September to November 2022 - % of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health has improved over the four months to November 2022 - all being above the target of 80% - % of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Service for adults aged 18 years+ has improved month-on-month from September to November 2022 and is nearly at target (76.3% against a target of 80%)	- The last four months, August to November 2022, have seen performance of % of therapeutic interventions started within 28 days following an assessment by Local Primary Mental Health Support Service - remain fairly static, but well below the target of 80% (for under 18 years) - % 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 in April 2022 - % of Mental Health assessments undertaken within 28 days from the date of receipt of referral for adults aged 18 years+ has been fairly consistent from December 2021 to November 2022 (mostly around 70% - against a target of 80%) - % of Health Board residents in receipt of secondary Mental Health services who have a valid care and treatment plan for adults 18 year+ has been very consistent between 81.7% to 87.1% over the past 12 months and not far from a target of 90%	- % of children and young people waiting less than 26 weeks to start an Attention Deficit Hyperactivity Disorder or Autistic Spectrum Disorders neurodevelopment assessment has slightly and steadily declined from June through to November 2022 - Complaints responded to in a timely manner has been trending downwards from September 2021 (68%) to November 2022 (approximately 22%) - against a target of 75%

Chapter 1

Quadruple Aim 1:

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

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1a: Weight Management
1b: Smoking

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Measures: Weight Management

Committee	Period	Measure	Target	Actual	Trend 2018/19	2019/20	2020/21	2021/22
QSE		Percentage of adults losing clinically significant weight loss (5% or 10% of their body weight) through the All Wales Weight Management Pathway	Annual Improvement	TBC	New Measure 2022/23, Awaiting Data			
QSE	2021/22	Percentage of babies who are exclusively breastfed at 10 days old	Annual Improvement	35.40%	34.6%	34.7%	36.1%	35.4%

Measures: Smoking

Committee	Period	Measure	Target	Actual	Trend 2018/19	2019/20	2020/21	2021/22
QSE	2021/22	Percentage of adults (aged 16+) reporting that they currently smoke either daily or occasionally	Annual Improvement	13.4%	New Measure for 2020/21		13.8%	13.4%
QSE	2022/23	Percentage of adult smokers who make a quit attempt via smoking cessation services	5% annual target	1.1%	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23
					1.20%	2.23%	3.31%	4.43%	1.09%

1c: Diabetes

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Measures: Diabetes

Committee	Period	Measure	Target	Actual	Trend Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
QSE	2021/22	Percentage of patients (aged 12 years and over) with diabetes who received all eight NICE recommended care processes	A quarterly improvement of 2.5% against a baseline of 2020-21	22.6%	14.2%	12.5%	17.1%	18.9%	22.6%

Committee	Period	Measure	Target	Actual	Trend 2018/19	2019/20	2020/21	2021/22
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 baseline data of 2020-21	25.7%	New Measure for 2020/21		29.1%	25.7%

1d: Substance Misuse

1e: Vaccinations

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Measures: Substance Misuse

Committee	Period	Measure	Target	Actual	Trend Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23
QSE	2022/23	European age standardised rate of alcohol attributed hospital admissions for individuals resident in Wales (episode based)	Annual Improvement	404.3	400.0	358.3	418.5	380.1	382.1	393.2	404.3	Await Data
QSE	2022/23	Percentage of people who have been referred to health board services who have completed treatment for alcohol misuse	Annual Improvement	76.3%	65.7%	82.3%	68.2%	74.5%	74.3%	74.1%	68.7%	76.3%

Measures:Vaccinations

Committee	Period	Measure	Target	Actual	Trend Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23
QSE	2022/23	Percentage of children who received 3 doses of the hexavalent '6 in 1' vaccine by age 1	95%	94.4%	95.5%	95.4%	94.8%	94.7%	95.3%	94.6%	94.0%	94.4%
QSE	2021/22	Percentage of children who received 2 doses of the MMR vaccine by age 5	95%	91.4%	93.5%	95.2%	94.1%	93.4%	92.5%	92.6%	92.9%	91.4%
QSE		Percentage uptake of autumn 2022 booster dose of the COVID-19 vaccinations in all eligible Wales residents by health board (SEE NOTES)	75%	New Measure - Awaiting Data								
QSE		Percentage uptake of 2022-23 influenza vaccination in all eligible Wales residents by health board (SEE NOTES)	75%	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

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University Health Board

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

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Betsi Cadwalar
University Health Board

Measures: Children and Adolescent Mental Health Services

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
QSE	Nov	Percentage of children and young people waiting less than 26 weeks to start an ADHD or ASD neurodevelopment assessment	80%	36.7%	36.1%	35.7%	39.0%	42.7%	43.0%	45.8%	46.3%	44.2%	41.2%	40.1%	39.6%	36.7%
QSE	Nov	Percentage of patients waiting less than 28 days for a first appointment for specialist Child and Adolescent Mental Health Services (sCAMHS)	80%	100.0%	100.0%	100.0%	54.5%	60.0%	100.0%	50.0%	66.7%	100.0%	100.0%	100.0%	Awaiting Data	
QSE	Nov	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%	47.0%	41.9%	33.3%	24.4%	38.0%	25.0%	26.1%	24.3%	35.1%	39.3%	26.1%	38.5%	47.0%
QSE	Nov	Percentage of therapeutic interventions started within (up to and including) 28 days following an assessment by LPMHSS for people aged under 18 years	80%	20.5%	54.4%	48.4%	33.3%	31.4%	18.2%	30.8%	20.1%	46.3%	26.5%	22.9%	26.9%	20.5%
QSE	Nov	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	80%	94.6%	93.9%	96.5%	92.3%	92.2%	93.3%	94.6%	89.2%	94.1%	93.0%	95.0%	93.3%	94.6%
QSE	2021/22	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	5.9	4.5 (2018/19)	5.2 (2019/20)	5.1 (2020/21)	5.9 (2021/22)								

Narrative 1: Children and Adolescent Mental Health Services

Why we are where we are

Performance against WG targets Nov 22: SCAMHS – 80% seen under 28 days. Mental Health Measure (MHM) Part 1a 47% 1b 20.5%, MHM Part 2 94.6%
- Performance position at end of November in line with WG approved improvement trajectories (regional) for Part 1a and 1b
- Consistently meeting MHM Part 2 and SCAMHS targets
- Demand for mental health assessment and intervention has increased by 5%
- Increase in N:R ration to 10:1 in comparison to pre-pandemic levels of 7:1, this is associated with increased complexity and acuity of patients seen nationally and impacts flow
- Recruitment of new posts within the service has seen internal transfer of staff which results in ongoing vacancies.

What we are doing about it

- Fortnightly check, challenge and support meetings with WG Delivery Unit in place
- Regional and local Choice and Partnership Approach (CAPA) action plans are under development for monitoring through TI Access Workstream from February 2023
- Monitoring of performance against improvement trajectory is ongoing across all teams and through the established Regional CAMHS Performance Delivery Group with escalation to Associate Directors and IHC Directors of Operations as appropriate
- Monthly scrutiny of external providers uptake and throughput
- Recruitment to posts identified in 2022/23 funding bids is ongoing with a focus on early intervention and prevention services to improve the early help offer within schools and primary care, manage demand into specialist services and increase capacity within core services
- Review of efficiency measures to improve access waiting times

When we expect to be back on track

- Revised trajectories agreed during November 2022 for recovery against MHM Part 1.
- Trajectories indicate achievement of MHM Part 1a by end of March 2023 and for Part 1b by end September 2023

What are the risks and mitigating actions

- Delays in recruitment are being supported by Programme Management Office (PMO) to ensure posts are advertised in a timely manner and promoted through Just-R recruitment campaign, social media and recruitment events through to the end of Q4.
- Ability to recruit to all new posts as investment receives equates to a 50% increase in staffing across the service
- Increased demands on services in terms of referrals received and acuity is monitored in IHC's on a weekly basis to ensure early escalations through TI Access Workstream and IHC's Senior Management Team
- Risk of increased crisis presentations with waiting lists, to mitigate teams liaise with patients waiting to ensure signposting and community support in place

Narrative 2: Neurodevelopment (ND)

Why we are where we are

Our performance against achieving the Welsh Government (WG) target at the end of October 2022 has reduced to 40% waiting within target to start a ND assessment. This is affected by:
- The gap between core capacity and demand is significant, at approximately 800 assessments per annum, 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.
- Delivery of phases 1 and 2 by external provider off trajectory with phase 3 capacity significantly lower than agreed levels due to lack of provider capacity

What we are doing about it

- Development and implementation of a service improvement and development plan is in progress; funding will be essential to make the impact required. Programme Manager is prioritising work streams.
- Recruitment and retention strategy will be developed to support building of sustainable teams across the region, specific review of psychology workforce under review. Support from workforce requested around specific workforce campaign. Development of an agreed model of care for the service, which will include co-production and testing models to ensure they meet needs
- We continue to work with the external provider to deliver a recovery plan for all phases of the contract.
- Ongoing use of external providers is essential in order to meet demand; approval of further tender approved by Performance Finance and Information Governance (PFIG) committee and is going for Ministerial approval. Anticipation of new contract to be in place by July 2023

When we expect to be back on track

- External provider performance escalated via risk register. Anticipate external provider trajectory will be completed by March 2023.
- Service Improvement and Development Plan under development through transformational and programme team with an incremental 3-5 year plan in order that a sustainable service fit for the future needs of our population is achieved.

What are the risks and mitigating actions

- Financial risks identified with phase 1 and 2 paid as per contract (paid on referral) with delivery outstanding. Recovery plan to ensure all outstanding referrals are closed prior to year end; phase 3 activity may impact on 2023/24 finances – no payment made currently this is been managed by finance team. No additional funding identified to increase internal capacity.
- Risk of reputational damage due to inability to deliver activity by external provider mitigated by contacting all patients to maintain open and clear communication.
- Ongoing risk around internal recruitment and retention impacting on internal capacity and skill mix mitigated through development of recruitment and retention strategy.
- Lack of external provider contract from April 2023, prioritisation of service redesign/improvement is essential for the sustainability of the ND service.

2b: Adult Mental Health Services

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University Health Board

Measures: Adults Mental Health Services

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
QSE	Oct	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%	100.0%	New Measure for 2022/23			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Await data	
QSE	Oct	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%	100.0%	New Measure for 2022/23			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	Await data	
QSE	Nov	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%	70.8%	66.2%	46.6%	63.2%	63.2%	54.5%	62.5%	69.5%	75.2%	77.1%	66.8%	72.2%	70.8%
QSE	Nov	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%	76.3%	73.5%	64.4%	79.8%	75.1%	77.8%	78.5%	82.2%	81.2%	72.9%	71.8%	73.4%	76.3%
QSE	Nov	Percentage of patients waiting less than 26 weeks to start a psychological therapy in Specialist Adult Mental Health	80%	89.8%	78.6%	76.2%	76.4%	74.3%	69.6%	64.4%	74.6%	79.4%	88.0%	93.7%	94.4%	89.8%
QSE	Nov	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%	83.8%	86.1%	87.1%	85.5%	85.4%	86.5%	86.7%	83.2%	81.7%	84.3%	84.2%	84.7%	83.8%

Narrative 1: Mental Health Measure

Why we are where we are

As at the end of November we are reporting 70.8% against part 1a, 76.3% for part 1b, 83.8% for part 2 and 100% for part 3 of the Mental Health Measure. Whilst we are currently off target, we are achieving the levels forecast as part of our improvement trajectory for the month of November. We have maintained the position achieved last month despite seeing an increase in referrals across some of our county teams in November, most notably in Ynys Mon, Gwynedd and Flintshire.

What we are doing about it

We continue to pursue all recruitment opportunities both substantive and temporary to ensure we can both provide a quality service and to ensure our existing staff are supported. Due to the significant improvements made in the East, the East team are now seeking to support colleagues in teams in other areas as a part of the mitigation of risk to delivery over the winter months. Focus remains on waiting list reduction with capacity being used to address both long waiters and clinical prioritisation. The 111 press 2 service will go live in January 2023 and we anticipate that this will alleviate some of the demand typically routed through to the Mental Health Measure teams. We will be monitoring this impact carefully through both the 111 reporting and the monitoring of the wider Mental Health and Learning Disability (MHLD) services.
Longer term solutions continue to be worked through and additional project support will be aligned to the development of Tier 0/1 service improvement work from January 2023. The work to date has been developed alongside the project for 111 press 2 and the Delivery Unit (DU) have been involved in the discussion, agreement and sign off of pathways that will enable effective patient management through our services.

When we expect to be back on track

Our current forecast will bring us to compliance with the measure at the end of March 2023. Routine monitoring of our activity and the contributing risk factors will allow us to rapidly assess any adjust for any deviation from the current trajectory

What are the risks and mitigating actions

Staffing remains our biggest risk factor both with recruitment to substantive posts, implementation of approved bank staff solutions and seasonal pressures on staffing including sickness. As noted above routine monitoring of risk factors will allow us to consider early alternate solutions to staffing provision and consider its impact on our forecast position.

Narrative 2: Adult Psychological Therapy

Why we are where we are

We are currently 90% (November 2022) compliant, well above the national 85% target. The National Delivery Unit have informed us we are now reporting the best compliance in Wales.

What we are doing about it

We continue the whole system strategic improvement work aimed at increasing and sustaining the staffing and associated supportive infrastructure to ensure long term improvements in access to specialist interventions in secondary care mental health services. This includes ongoing capacity/demand analysis, stepped care training and supervision to MDT colleagues to increase access to lower step interventions (as per Matrics Cymru guidance), waiting list review and no waits prioritising and fast track high risk and need, proactive recruitment efforts, and active support for existing staff to ensure retention. In year we have been working closely with HEIW on the national Clinical Associate in Applied Psychology (CAAPs) workforce pilot, and are due to start 2 new Clinical Associates in January 2023 as a proof of concept to increase the available workforce and are also training additional psychologists as per Health Education Inspectorate Wales (HEIW) funded places and the national workforce plan. We continue the programme of increased access to and modes of delivery, including face to face groups and online delivery. We have service level research to indicate their benefit to service users across North Wales, in multiple teams and tiers of service within primary care mental health and secondary care mental health teams. We have recently taken part in the national review of waiting time targets by the National Delivery Unit, and look forward to further recommendations on these targets next year.

When we expect to be back on track

Currently on track but we remain vigilant in our monitoring due to the risks noted below.

What are the risks and mitigating actions

With a small specialist resource and the national picture of increased demand for psychological input (the pandemic and economic crisis impact), there remains constant challenges such as maternity leaves, sickness, and staff turnover vacancies to manage on a day to day basis. We continue to try and address the capacity demand mismatch by proposing plans for Service Improvement Funding (SIF) to further build and improve the available resource and infrastructure within Betsi Cadwaladr University Health Board (BCUHB) to sustain these improvements long term and manage the increase in demand which we are now seeing post pandemic, and are actively seeking ways to attract new qualified recruits to BCUHB by networking.

2c: Hospital Infection Control

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Measures: Hospital Infection Control (bacteraemia cases)

Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
QSE	Nov	Cumulative number of laboratory confirmed bacteraemia cases: Klebsiella sp	HB Specific TBC	101.0	108	119	127	138			29	42	59	65	89	101
QSE	Nov	Cumulative number of laboratory confirmed bacteraemia cases: Aeruginosa	HB Specific TBC	25	31	33	36	37					14	14	21	25
QSE	Nov	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: E-coli	HB Specific TBC	75.3	64.4	62.6	63.7	62.1	*	68.1	66.7	74.4	74.6	78.0	75.7	75.3
QSE	Nov	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: S.aureus bacteraemias (MRSA and MSSA)	HB Specific TBC	26.8	27.0	28.0	27.0	25.9	*	31.5	35.9	33.2	30.5	29.8	30.1	26.8
QSE	Nov	Cumulative rate of laboratory confirmed bacteraemia cases per 100,000 population: C.difficile	HB Specific TBC	41.7	35	32	32	31	*	37	37	43	46	44	43	42

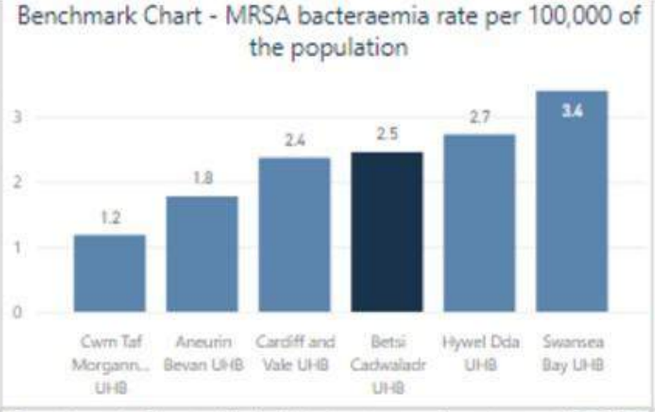
*Data not available

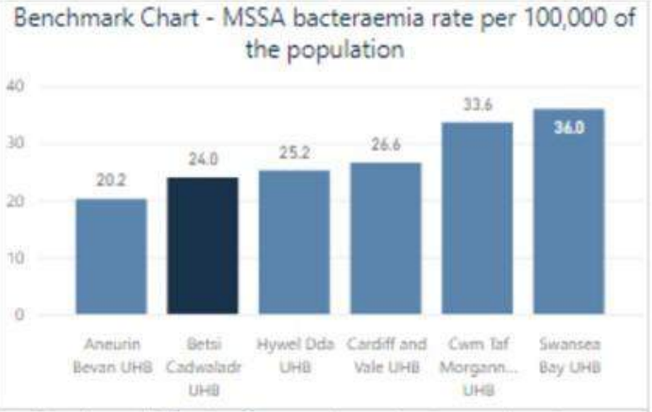
Measures: Hospital Infection Control (COVID-19 cases)

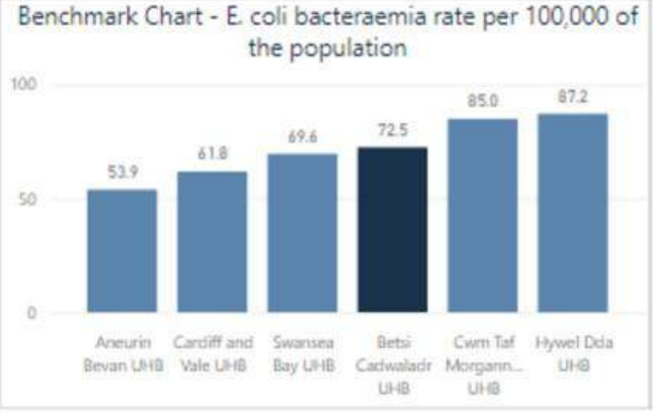
Committee	Period	Measure	Target	Actual	2021 D	2022 J	F	M	A	M	J	J	A	S	O	N
QSE	Sep	Percentage of confirmed COVID-19 cases within hospital which had a definite hospital onset of COVID-19	Reduction against the same month in 2021-22	47.9%	43.7%	43.1%	35.5%	40.5%	40.5%	28.6%	45.8%	33.8%	36.7%	47.9%		Await Data
QSE	Sep	Percentage of confirmed COVID-19 cases within hospital which had a probable hospital onset of COVID-19	Reduction against the same month in 2021-22	19.0%	12.0%	12.5%	9.0%	13.3%	15.3%	18.1%	13.9%	16.9%	24.5%	19.0%		Await Data

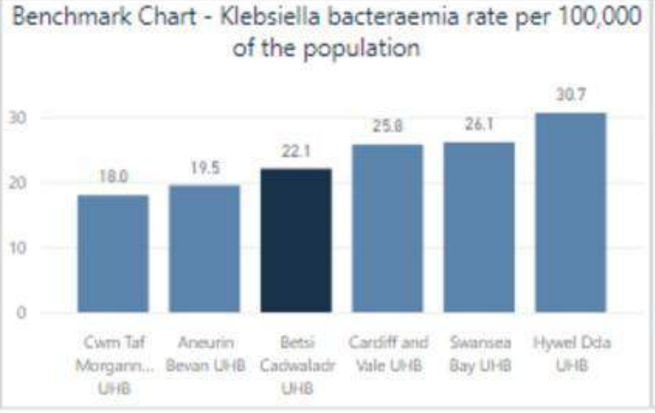
Charts: Comparison - All Health Boards in Wales

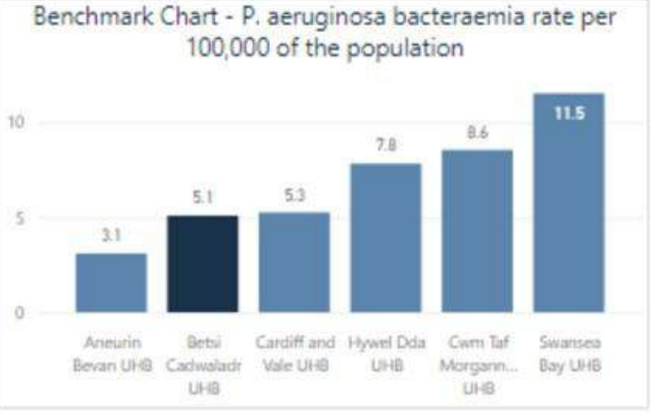
Apr 2022 to Mar 2023











Narrative 1: Infection Prevention - CDI and Bacteraemias

Why we are where we are

- C.difficile: patient reviews identified learning including delayed sampling and isolation leading to increased environmental bioburden and then Deep cleaning with HPV/Hypochlorus acid not being done. Reoccurrences are not being referred for faecal transplant in a timely manner.
- MRSA bacteraemias: there were 4 new cases in December (3 in East, 1 in Central) which are being investigated and will be reported to IPSG.
- MSSA bacteraemias: the rate has reduced in the last 2 months. Cases reviewed but no commonalities identified.
- For gram negatives (E.coli, Pseudomonas, Klebsiella), rates have increased slightly; majority classed as unavoidable but some related to urine infections and urinary catheters.

What we are doing about it

- Detailed Patient Incident Reviews (PIR) are being completed for each infection and reviewed by a multi-disciplinary team.
- Re C.difficile: the new Faecal Transplant SOP has been approved and leads are being sought at each site. Prior to Xmas good progress was being made with the Deep clean programme. When flu and COVID numbers settle there is to be a C.difficile awareness campaign launched.
- Pseudomonas: A mapping exercise was carried out; there was no correlation found between patient infections and fails in water sample testing.
- Plan to include an improvement project to reduce catheter associated urinary tract infections (CAUTI) in the Safe Care Collaborative work.

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. Target rates are supposed to be achieved by March 2023. Common issues identified from PIRs are being used as the focus for the Safe Clean Care - Harm Free Campaigns. Improved processes for sharing lessons learnt are being introduced.

What are the risks and mitigating actions

- 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.
- Lack of PHW Microbiology support to review and advise on cases.
- Resource within the Infection Prevention team hampered by high sickness levels - risk assessment in place with actions & work being prioritised.

Narrative 2: COVID-19

Why we are where we are

- Following a risk assessment, visiting hours were increased slightly over the Christmas period.
- Masks were reintroduced in November 2022 for all staff, visitors and patients.
- Numbers of patients arriving with respiratory symptoms increased significantly in December 2022.
- There is a lack of siderooms to isolate positive cases and a number of small outbreaks have occurred.
- Emergency departments are being stretched with a high number of attendances.

What we are doing about it

All patients with respiratory symptoms are tested for COVID-19, Influenza and RSV.
PHW are leading research to understand at ward level, what might predict a COVID-19 outbreak e.g. staffing rates, ward turnover, community transmission rates and ventilation.
Respiratory impact data is being collected at all sites now by the IP team.
A risk assessment, based on the latest Welsh guidance, for cohorting patients or contacts of those with confirmed respiratory infections, was approved in late December.

When we expect to be back on track

- Unknown, but total numbers of flu and COVID positive patients fell slightly on 6/1/23. The situation and trends in data continue to be monitored 3 times per week by IP and reported to the Emergency Preparedness Resilience and Response Lead and the Winter planning group.
- Need to remain vigilant concerning the potential impact of new COVID variants arising e.g. from China – all patients who have travelled there in the last 14 days should be identified and samples sent for typing.

What are the risks and mitigating actions

- Staff must be up to date with the latest changes in policies and protocols and remain vigilant; Communications are sent out globally when changes are made and policies and protocols on the intranet site are kept up to date.
- There is significant pressure on patient flow preventing appropriate patient movement – IP 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

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3a: Staff Resources
3b: Staff Engagement

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Betsi Cadwalar
University Health Board

Measures: Staff Resources

Committee	Period	Measure	Target	Actual	Trend 6-months ending: Mar-22	Sept-22
QSE	2022/23	Percentage of staff who have recorded their Welsh language on ESR who have Welsh language listening/speaking skills levels 2 (foundational level) and above	Bi-annual improvement	34.4%	33.9%	34.4%

Measures: Staff Engagement

Committee	Period	Measure	Target	Actual	Trend 2018/19	2019/20	2020/21
QSE	2020/21	Overall staff engagement score	Annual Improvement	73.0%	71%	75%	73%
QSE	2020/21	Percentage of staff who report that their line manager takes a positive interest in their health and well-being	Annual Improvement	62.8%	New Measure for 2022/23	68.0%	62.8%

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

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4a: Clinically Effective Prescribing

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

Measures: Clinically Effective Prescribing

Committee	Period	Measure	Target	Actual	Trend	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23
QSE	Jun	Total antibacterial items per 1,000 specific therapeutic group age-sex related prescribing units (STAR-PUs)	Primary care health board target: a quarterly reduction of 5% against a baseline of 2019-20	255.2		234.2	215.4	221.8	243.8	289.8	250.1	255.2	Q1 22/23 Latest
QSE	N/A	Percentage of secondary care antibiotic usage within the WHO Access category	55%		Due to data issues this measure has been removed from the framework until further notice								
QSE	Jun	Number of patients aged 65 years or over prescribed an antipsychotic	Quarter on quarter reduction	2,343		2469	2419	2451	2451	2462	2420	2343	Q1 22/23 Latest
QSE	Jun	Opioid average daily quantities per 1,000 patients	4 quarter reduction trend	4,649.9		4943.8	4666.0	4801.7	4821.8	4910.8	4644.9	4649.9	Q1 22/23 Latest

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

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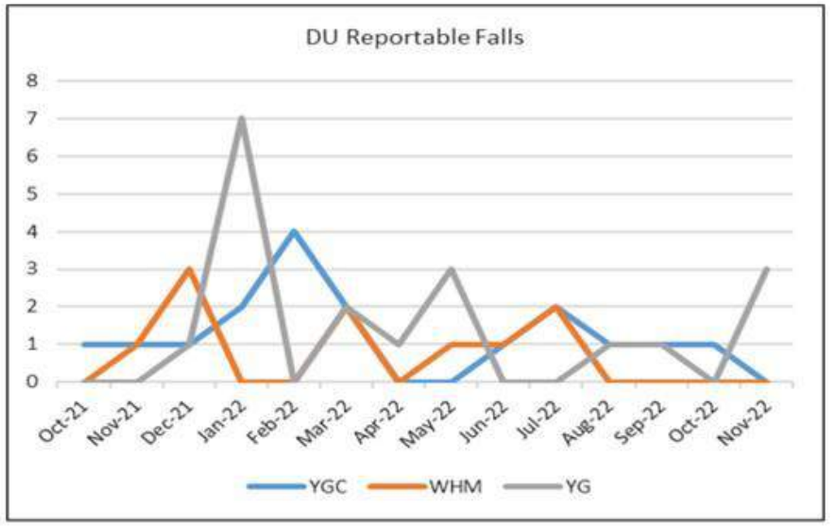
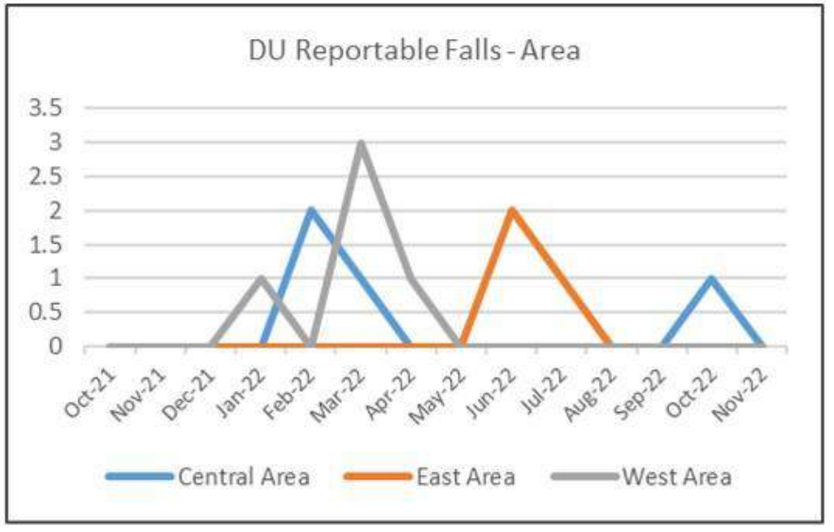
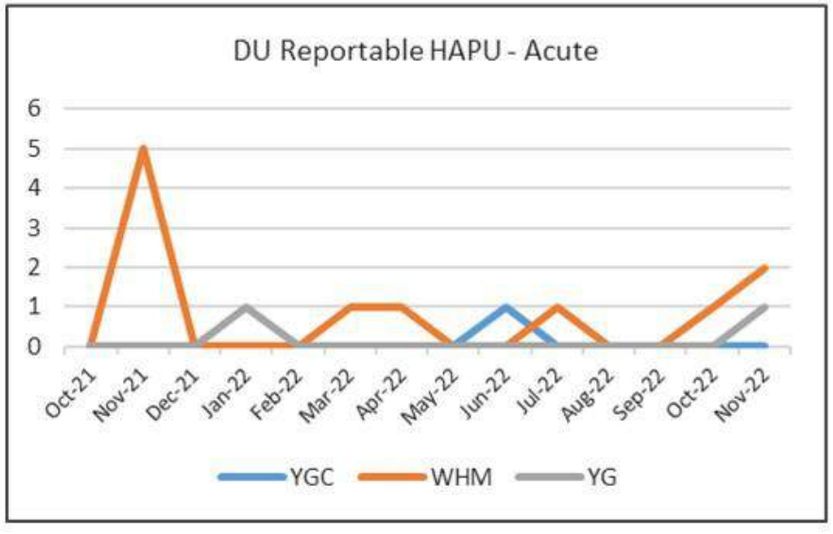
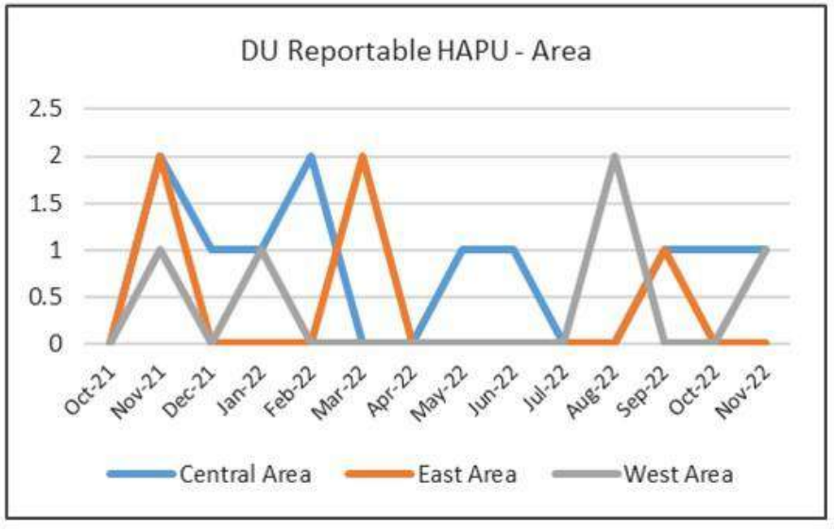
Charts 1: Incidents

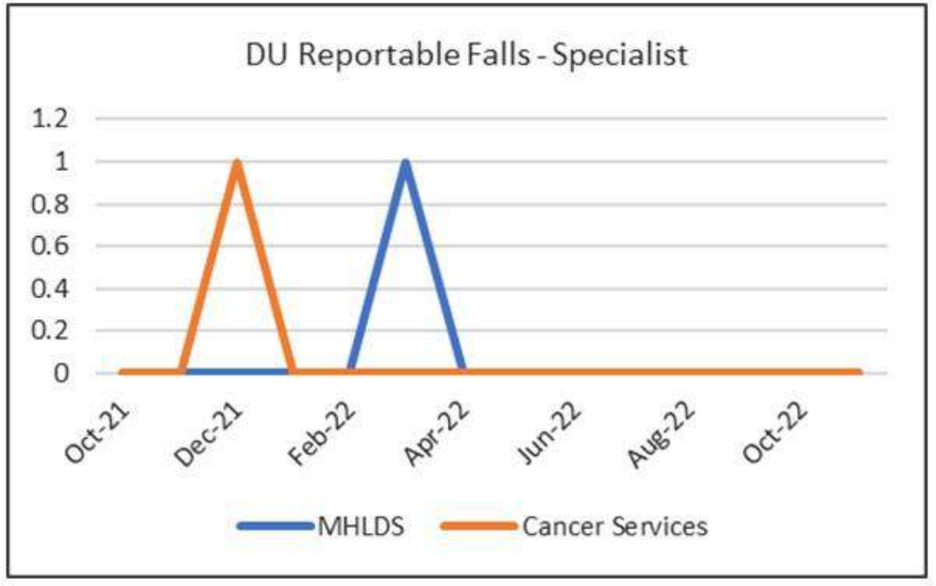


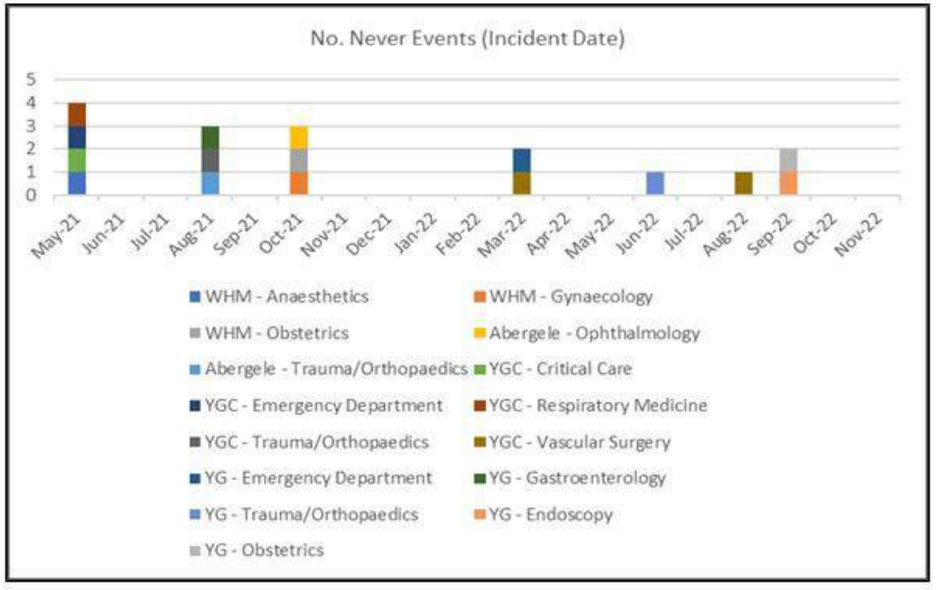






Charts 2: Incidents





Narrative: Incidents

Why we are where we are

During this time period there were zero never events reported. There were seven healthcare acquired pressure ulcers (HAPUs) (grades 3, 4 and ungradeable) reported and five falls (with harm) reported. Further details are found in the Patient Safety Report.
There is one patient safety alert for which compliance is overdue (PSA057 – Emergency steroid therapy cards). The Deputy Executive Medical Director is leading work to ensure compliance with the notice.

What we are doing about it

In respect of the top three themes, there is ongoing work led by the Falls Improvement Group, Sepsis Trigger, Escalation and Antibiotic stewardship Review (STEAR) Improvement Group and the HAPU improvement Group, all of which take a collaborative approach to improve patient safety underpinned by improvement methodology. Further details are found in the Patient Safety Report.

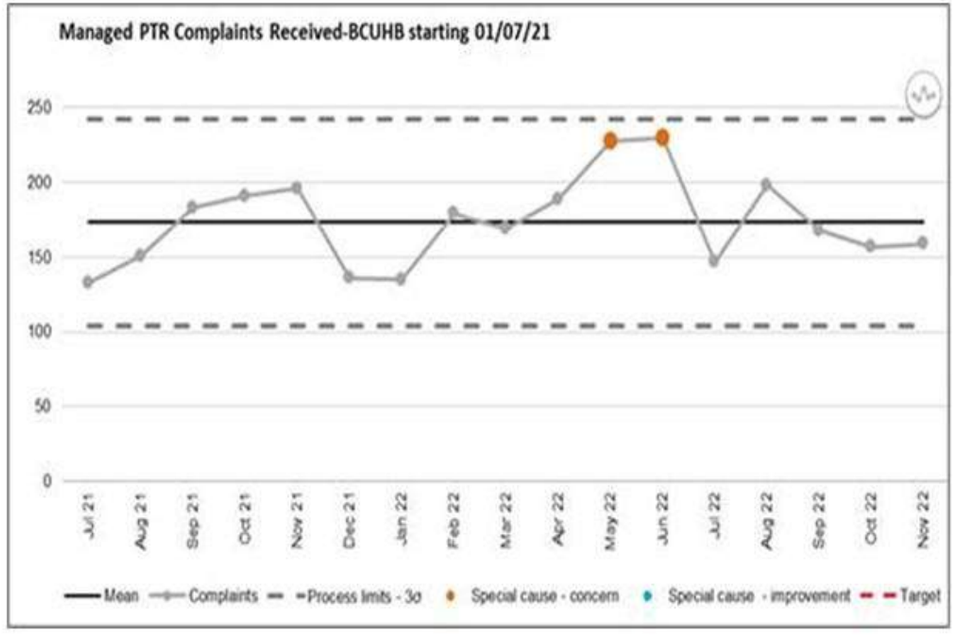
When we expect to be back on track

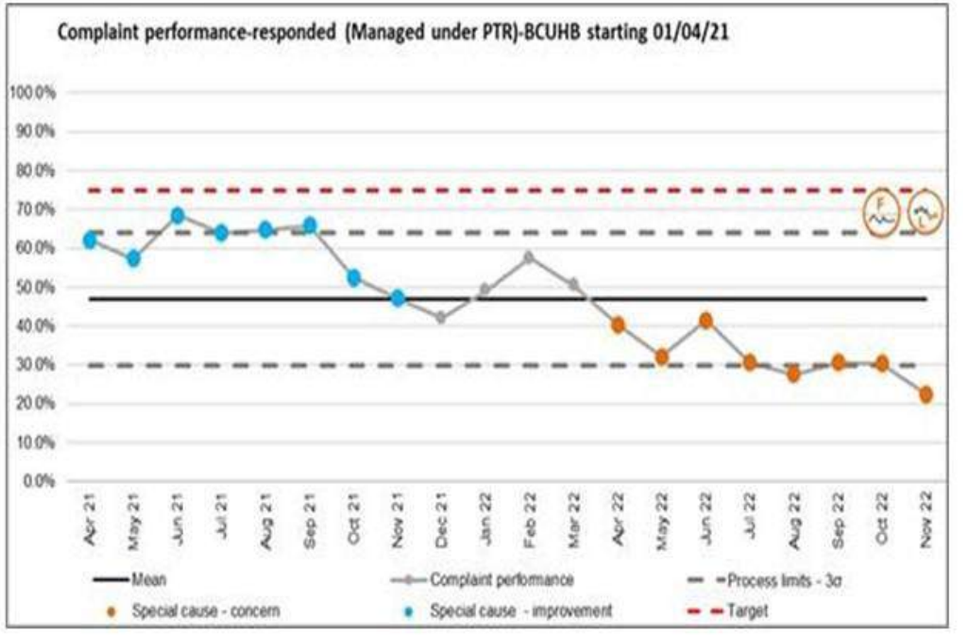
The overdue incident review position is being progressed and the aim is to achieve the national targets by April 2023. Further details are included in the Patient Safety Report.

What are the risks and mitigating actions

The capacity within services to manage both the current and backlog position of investigations is a main risk – weekly reporting is in place. The system for sharing and embedding of learning remains a risk for the organisation. As part of the restructure of the Quality Team, there are plans for a dedicated team that will be tasked with developing and improving the way in which the Health Board shares learning. An Organisational Learning Forum is being established in February 2023.

Charts: Complaints





Narrative: Complaints

Why we are where we are

During the months of October and November 2022, 26.33% (average) of complaints were responded to within 30 working (against a target of 75%). 487 complaints were overdue in October which reduced to 342 complaints overdue at the end of November. The consistent themes highlighted were particularly in relation to treatment and care, discharge, communication and appointment waiting times. 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. However, the services have worked pro-actively with the support of the Complaints Team and Patient Advice Liaison Service (PALS) to provide a proactive, timely resolution to enquiries, Grade 1 and 2 complaints, which has contributed to a reduced number of open complaints and a focus on addressing the backlog of overdue complaints.

What we are doing about it

A weekly complaints report is cascaded across all services with proactive support by the Complaints Team. Scrutiny is consistently being applied, ensuring that all complaints are managed under Putting Things Right (PTR) 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 PTR where there is no allegation of harm, particularly Grade 1 complaints. 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. The team continues to work with services to provide accurate and detailed performance data on a weekly basis with a new complaint management approach adopted via “rapid resolution workshops” to resolve the backlog of overdue complaints. In addition, empowering staff to resolve low level concerns by offering on site training sessions, caseload review sessions, weekly reviews with the Executive Director of Nursing who is personally responding to lower level complaints ensuring consistent Executive management level involvement.

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 mitigating actions

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

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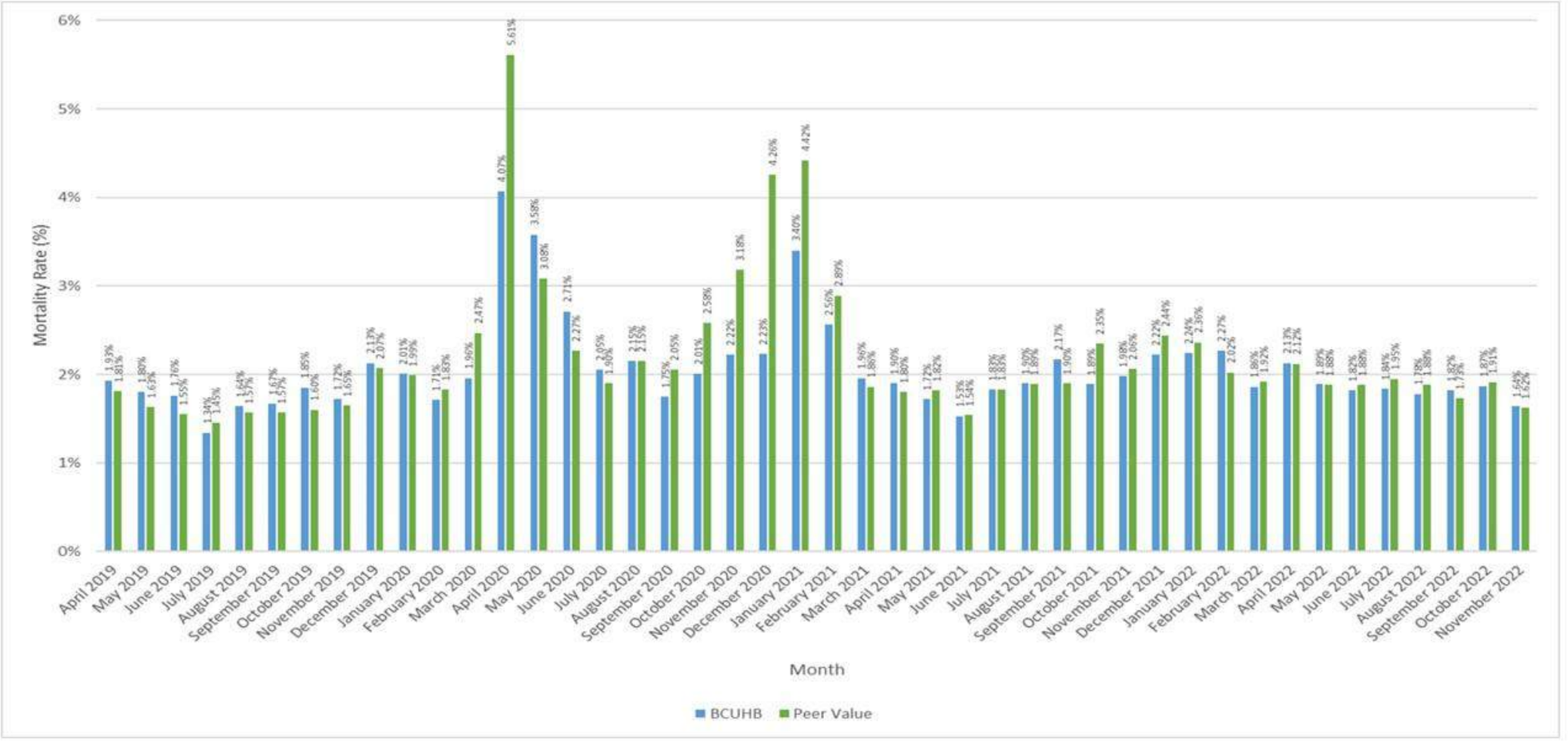
Mortality Rate BCUHB vs. Peers



Narrative: Mortality

Why we are where we are

The Medical Examiner oversight backlog has now been addressed and the Mortality team are currently inputting cases received from mid-November 2022 onwards. Whilst this is an achievement, resource is still required to input and process the 30 cases on average received each week. The clinical review front log is being maintained but the backlog is more difficult to overcome with current resource. Due to Deputy Medical Director re-structure, the Integrated Health Communities (IHC's) continue to require resource to effectively manage the mortality cases referred to them for review. A more robust Datix system is required, talks are being held with Datix, but progress is slow, and there are ongoing changes as the service evolves. The All Wales Mortality Framework document is still in draft for final sign off, so further work may need to be done after review.

What we are doing about it

We have sourced an additional Band 3 inputter on a bank contract to support with mortality reviews into Datix, as the facilitator role is becoming more strategic. We have advertised for extra clinical hours via bank hours and a secondment, however we have not been able to achieve any interest, and will continue to promote in the New Year. The corporate mortality team are planning to meet the IHC's to discuss their processes and suggest change if necessary. Internal drive is required to get the learning from inquests more disseminated; tying in with the ME work and themes.
A mortality team representative attends a fortnightly meeting with the Delivery Unit (DU) and other Welsh Health Boards to work through the development up to sign off of the mortality framework document, also meeting with Patient Safety Datix manager on a regular basis to improve the mortality datix system, for both the corporate team and IHC users. Some of the requests have also been submitted to the Once for Wales team via the DU's Mortality Work stream meeting.

When we expect to be back on track

We are a developing service and review practices on a weekly basis and any outstanding issues are identified at the Clinical Effectiveness Group.

What are the risks and mitigating actions

With any backlog, we are not reviewing patients deaths in real time as we are reviewing retrospectively, conversations between the MES and organisation with relatives can have a lengthy gap before next of kin issues are dealt with, making this a more protracted problem. We carry out an administrative sort and sieve to PALS however there is still the backlog itself, which also may have high risk issues not dealt with until the case is inputted onto the system and clinically reviewed; we have come across clinical high risk issues that no one else has picked up anywhere within the PTR process and are seemingly only being dealt with when they get to the mortality service. The Clinical Project Lead and Mortality AMD are working extra hours occasionally, to carry out clinical reviews, also although we have bank and support short term for the mortality team it is difficult to get up to date with all the processes required for mortality reviews.
Regularly meet with the DU to discuss the new framework where staffing resource, processes, datix, backlogs are regularly talked about to consider an All Wales approach.

Additional Information

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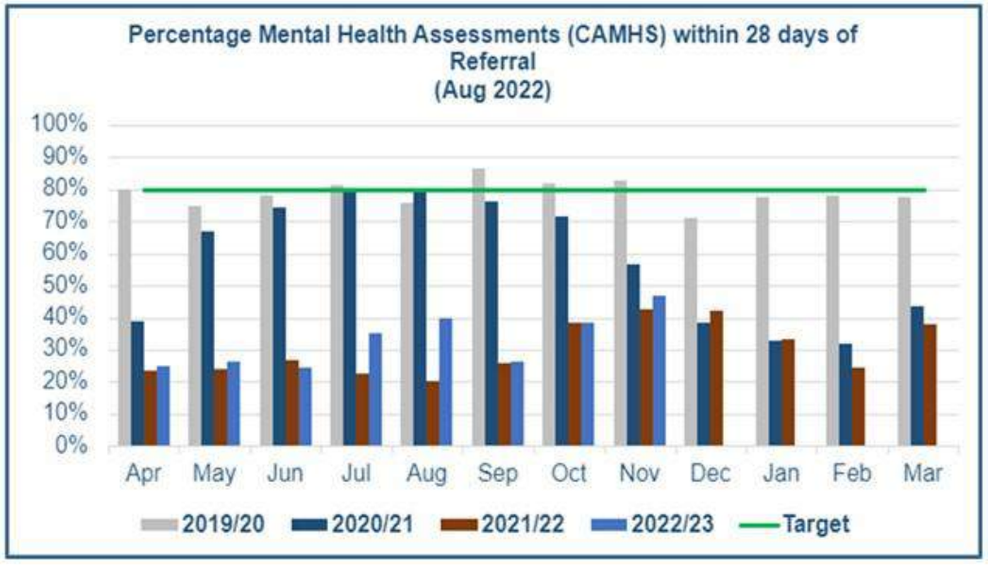
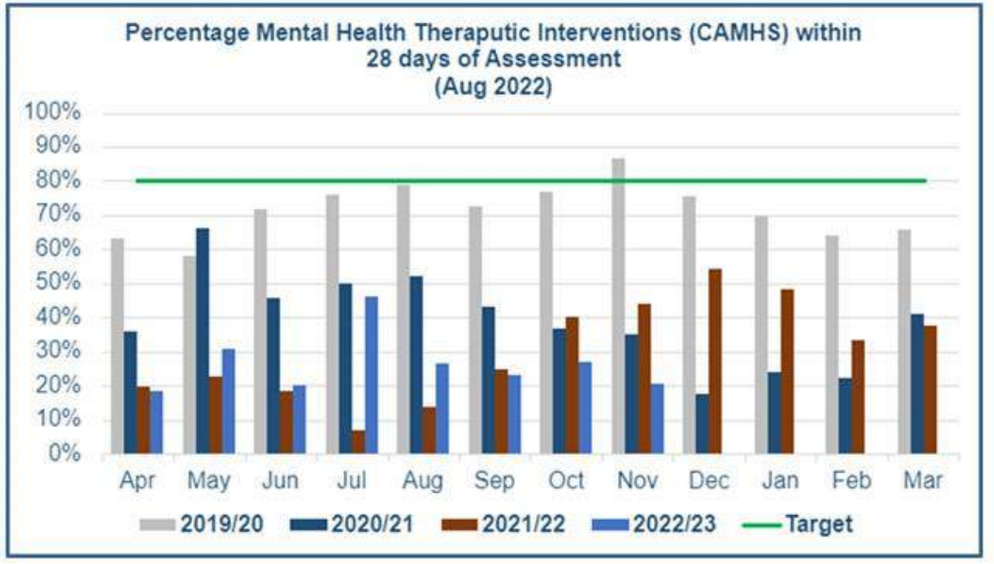
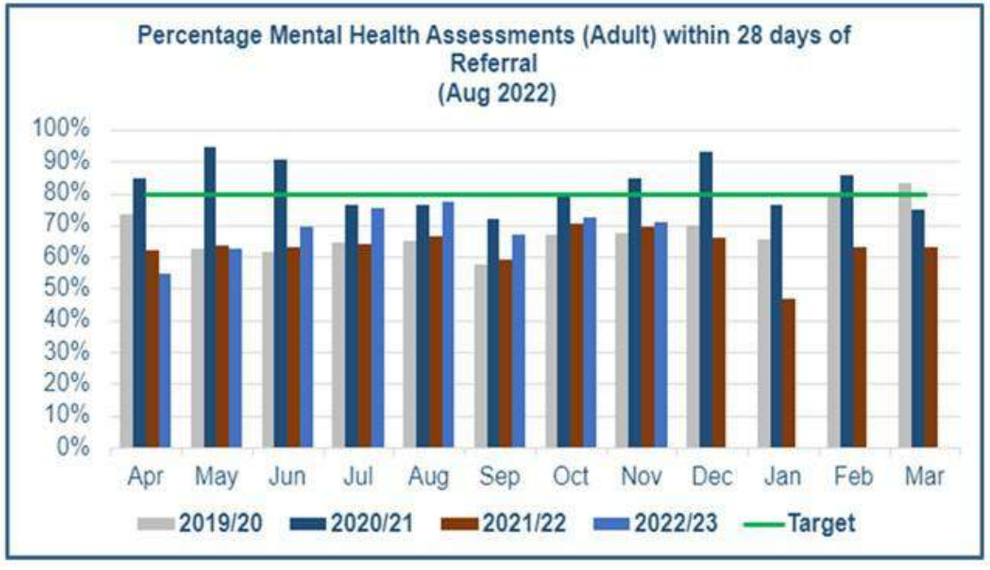
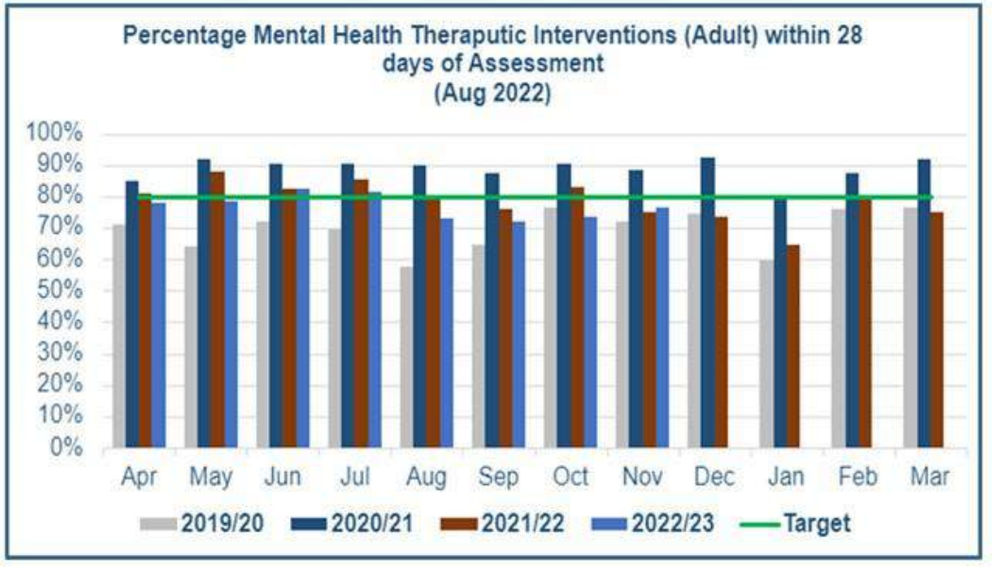
Charts: CAMHS



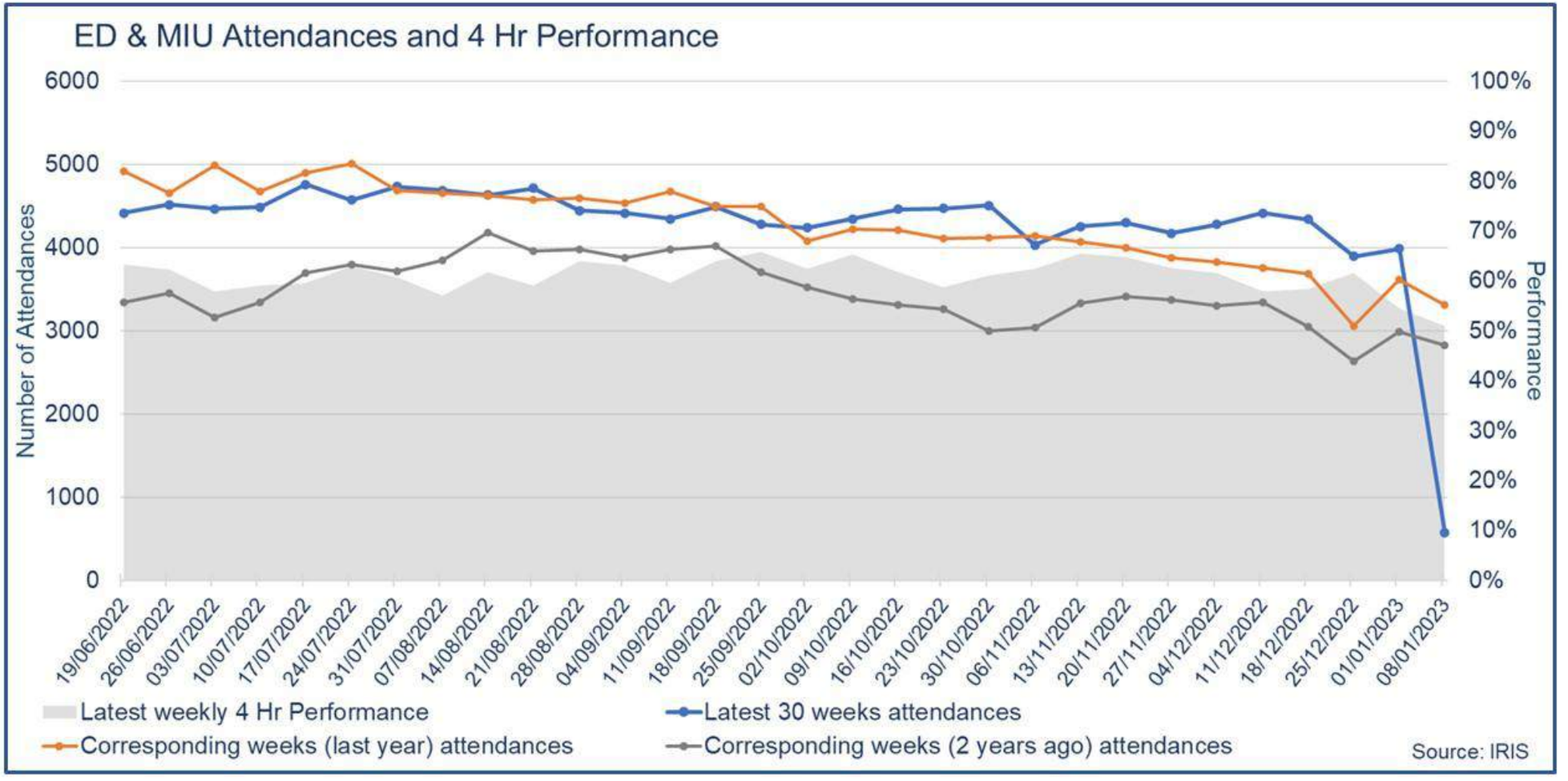


Charts: Adult Mental Health





Impact of COVID-19 Pandemic on Unscheduled Care



Impact of COVID-19 Pandemic on Unscheduled Care

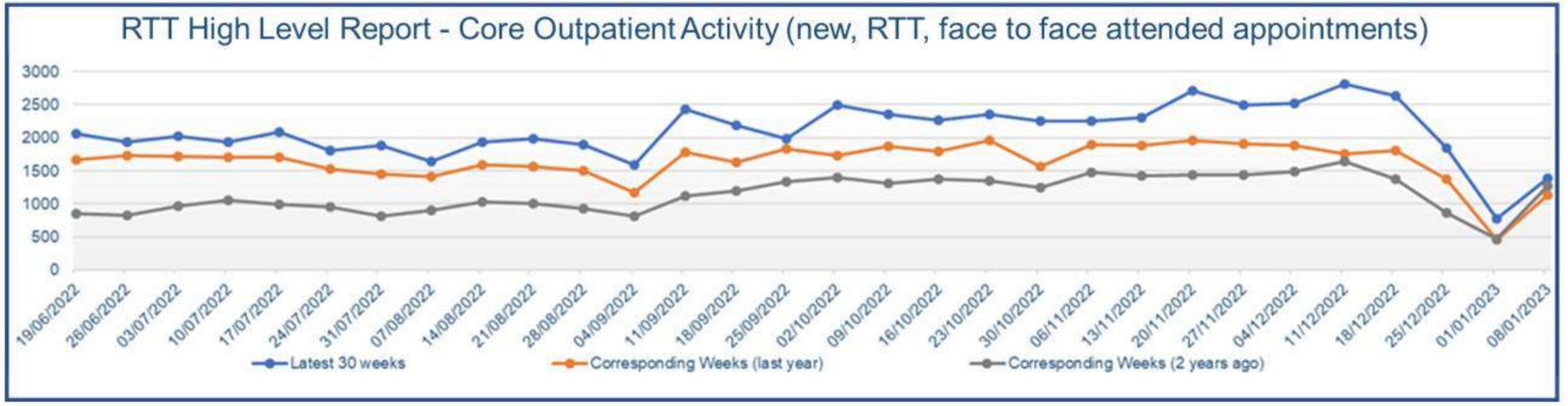
Position as at end of 8th January 2023	Sep 22	Oct 22	Nov 22	Dec 21	Dec 22	January 1st - 8th 2022	January 1st - 8th 2023
ED&MIU 4 Hour Performance	62.94%	61.87%	64.00%	60.24%	58.75%	59.19%	**62.92%**
ED 4 Hour Performance	50.83%	50.18%	53.18%	50.96%	48.76%	50.96%	**54.14%**
ED 12 Hour Breaches	3106	3178	2802	2501	3383	698	**694**
1 - 2 Hour Ambulance Handover	547	552	617	612	500	184	**130**
2 - 3 Hour Ambulance Handover	355	402	373	379	325	99	**89**
3 - 4 Hour Ambulance Handover	272	279	259	261	269	65	**78**
4 - 5 Hour Ambulance Handover	244	242	214	168	233	49	**54**
Over 5 Hour Ambulance Handover	490	552	408	323	798	102	**193**
Red 8 Minute	45.45%	45.00%	44.83%	48.05%	37.62%	45.18%	**44.27%**

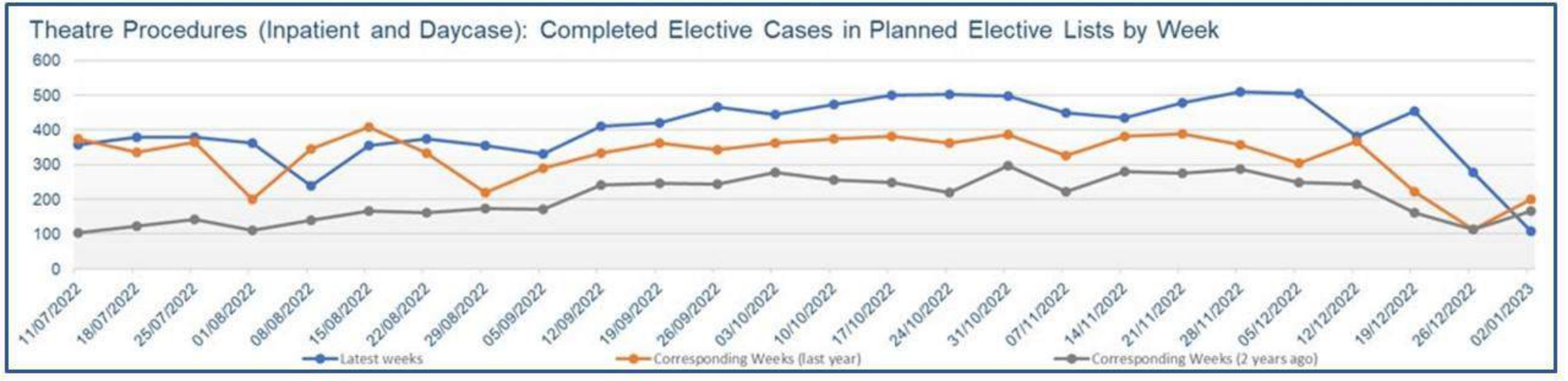
Red 8 Minute data from Nov 22 onwards is unvalidated and not for sharing outside this report.

Sources: Red 8 Minute - StatsWales (to Oct 22) and WAST Health Board Area Report
ED and Handover - IRIS, accessed 10/01/2023

Impact of COVID-19 Pandemic on Referral Rates

Impact of COVID-19 Pandemic on Planned Activity





Further Information

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Betsi Cadwalar
University Health Board

Further Information

Quality & Performance Report
Betsi Cadwaladr University Performance, Finance & Information Governance 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